Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

South Carolina Focused Program Integrity Review

Final Report

June 2017

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Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of South Carolina to determine the extent of program integrity oversight of the managed care program at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2011.

Background: State Medicaid Program Overview

The CMS review team conducted the onsite portion of the focused program integrity review of the state Medicaid agency by meeting with representatives from the offices of the South Carolina Department of Health and Human Services (SCDHHS). The SCDHHS is the organization responsible for implementing the Medicaid program in South Carolina. Since 1996, South Carolina has been operating its managed care program through its comprehensive risk-based MCO program. In 2011, the state further expanded managed care through its Healthy Connections Choices program and began enrolling additional Medicaid beneficiaries formerly served in the fee-for-service (FFS) delivery system in either the MCO program or the Medical Homes Network Program on a mandatory basis; however, children in foster care and with certain disabilities, Medicaid waiver enrollees, certain people served in institutions, and dual-eligible beneficiaries remained exempt from mandatory managed care. The state has also added inpatient behavioral health services to the MCO benefit package and, as of October 2013, expanded mandatory managed care to include all children under the age of one.

South Carolina provides Medicaid services to more than approximately 1.2 million enrollees and, with the exception of the Children's Health Insurance Program, is not a Medicaid expansion state. As of early 2016, approximately 793,424 beneficiaries, or 65 percent of South Carolina's Medicaid population, were enrolled in managed care. The remaining 35 percent, or approximately 427,228 beneficiaries, were enrolled in a FFS delivery system. The Healthy Connections Choices assists eligible members to enroll in state Medicaid health plans. South Carolina's total Medicaid expenditures for federal fiscal year (FFY) 2015 was $6.2 billion. The SCDHHS had six MCOs with $2.7 billion total expenditures in managed care contracts as of FFY 2015, and the state's Federal Medical Assistance Percentage for the same time period was 70.64 percent.

Methodology of the Review

In advance of the onsite visit, CMS requested that South Carolina and the MCOs selected for the focused review complete a review guide that provided the CMS team with detailed insight into the operational activities of the areas that were subject to the focused review. A three-person team has reviewed these responses and materials in advance of the onsite visit.
During the week of May 2, 2016, the CMS review team visited with representatives from South Carolina's Division of Program Integrity (DPI) which is located in the SCDHHS. They conducted interviews with numerous state staff involved in program integrity and managed care.

The CMS team also conducted interviews with three MCOs and their special investigations units (SIUs). In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating 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, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, approximately 793,424 beneficiaries, or 65 percent of the state's Medicaid population, were enrolled in six MCOs during FFY 2015. The state spent approximately $2.7 billion on managed care contracts in FFY 2015.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs as part of its review. The three MCOs' Medicaid managed care expenditures totaled 1.8 billion.

The SIU staff of BlueChoice HealthPlan of South Carolina (BlueChoice), Absolute Total Care (ATC), and Select Health of South Carolina (Select Health) discussed their program integrity activities at length. As indicated previously, each MCO is operating under the Healthy Connections Choices managed care model contract as of July 2014. The contract was renewed July 2016. BlueChoice is a local plan owned and operated by BlueCross BlueShield of South Carolina. BlueChoice is offered in almost every county in the state. BlueChoice launched its first health maintenance organization in 1984. In 2008, BlueChoice added a Medicaid option for beneficiaries who are eligible in South Carolina. Its SIU is located in Tampa, Florida and is solely dedicated to the Medicaid line of business and fraud, waste, and abuse efforts.

The ATC is a local plan providing full-risk managed care for Temporary Assistance to Needy Families and Supplemental Security Income members under the South Carolina's Medicaid program since 2007. The ATC operates in all 46 counties in the state of South Carolina. The The ATC is a wholly owned subsidiary of Centene Corporation (Centene) providing services that are not limited to medical, home health, disease management, and behavioral health. Centene operates in 21 markets. The ATC utilizes staff from Centene's SIU which is located in Chesterfield, Missouri. The SIU and several vendors work to identify aberrant billing patterns and track program integrity activities. The SIU is comprised of one investigator and one clinical staff member; both FTEs are fully-dedicated to program integrity activities, but are not solely dedicated to the South Carolina Medicaid Program. In addition, one manager and one analyst are dedicated 25 percent of the time to Medicaid fraud and abuse investigations. The ATC

compliance officer is located in South Carolina and is the liaison for coordination of activities, and reviews all SIU recommendations and contractual requirements.

Select Health is a local plan owned and operated by the AmeriHealth Caritas family of companies. AmeriHealth Caritas is a national insurance company and operates in nine states. Select Health serves beneficiaries in all 46 counties through the First Choice health plan and is one of South Carolina's largest health care insurers. The MCO became operational in 1996. The parent company's SIU is located at the AmeriHealth corporate offices in Philadelphia and serves all lines of business. The national SIU is a division of the Payment Integrity Department (PID) which currently employs 50 full time equivalents (FTEs). Three FTEs are fully-dedicated to Select Health program integrity activities, but are not solely dedicated to the South Carolina Medicaid Program. One FTE works remotely from Florida, while the other two FTEs are physically located in South Carolina. The SIU is responsible for conducting fraud, waste, and abuse audits. The PID identifies and collects any potential overpayments.

Table 1.

	BlueChoice	**ATC**	**Select Health**
Beneficiary Enrollment Total	78,567	103,638	325,953
Provider Enrollment Total	12,900	12,258	9,954
Year Originally Contracted	2008	2007	1996
Size and composition of SIU	2.5 FTEs	2.5 FTEs	3.0 FTEs
National/Local Plan	Local	Local	Local

Table 2.

MCOs	**SFY 2013**	**SFY 2014**	**SFY 2015**
BlueChoice	$219.0 million	$229.0 million	$292.0 million
ATC	$346.0 million	$403.0 million	$420.0 million
Select Health	$742.0 million	$938.0 million	$1.01 billion

*MCO data provided on a state fiscal year (SFY) basis.

State Oversight of MCO Program Integrity Activities

The SCDHHS is responsible for Medicaid program integrity activities for all service delivery systems. The DPI is dedicated to fraud, waste, and abuse activities, and is engaged in program integrity activities and oversight to protect the Medicaid managed care program by identifying, preventing, and recovering losses resulting from fraud, waste, and abuse. The DPI ensures that Medicaid and other funds are used effectively, efficiently, and in compliance with applicable state and federal laws and policies. Their statewide surveillance and utilization control systems safeguard against fraudulent, abusive, inappropriate, and excessive use of Medicaid resources. If Medicaid provider fraud is suspected, DPI turns the case over to the Medicaid Fraud Control Unit (MFCU) located in the State Attorney General's Office. Beneficiary fraud cases are referred to the Medicaid Recipient Fraud Unit which is also located in the State Attorney General's Offices.

Program integrity activities performed by the DPI include, but are not limited to: managing the fraud and abuse hotline; receiving complaints and tips regarding suspected fraud and abuse; conducting audits and investigations of health care providers, facilities, suppliers, and beneficiaries; identifying and recovering overpayments; detecting inappropriate utilization of benefits; making referrals to external law enforcement and regulatory agencies; and imposing provider sanctions which include exclusions and terminations for cause.

The Division of Health Services Operations is responsible for monitoring MCO contract performance, deliverables, and the quality of tasks performed by their six MCOs. Depending upon the deadlines for deliverables, other SCDHHS areas may be responsible for review and/or follow up activities. The program integrity unit (PIU) of SCDHHS serves as the primary lead for all program integrity-related issues. The staff in the Division of Health Services Quality oversees the external quality review organization’s (EQRO) contract and deliverables. However, program integrity is not a part of either division’s oversight nor does the EQRO contractor perform any tasks pertaining to program integrity. The DPI is responsible for monitoring the program integrity portion of the MCO contract which involves performance, deliverables and the quality of tasks performed. The managed care coordinator housed in the PIU, along with other DPI staff, oversees their program integrity managed care program and MCO contract’s program integrity component.

During the onsite review, the vacancies in staffing were also discussed with the state. The DPI has 31 positions allocated to program integrity activities; however, only 21 of those positions are currently filled. These positions are fully-dedicated to providing program integrity oversight. The ten vacant positions include: one program integrity program manager; one nurse manager; two nurse reviewers; two SURS analysts; one MCO coordinator; one pharmacy lock-in investigator; one hotline employee; and one ancillary reviewer. The staffing level is 32 percent understaffed and essential program integrity positions are vacant. However, DPI referred to other staffing resources available to assist with program integrity operations, activities and contract performance. Additional FTEs in the Internal Audits Division, the Division of Health Services Operations, the Division of Health Services Quality, and the South Carolina Office of the Inspector General may be utilized by DPI, if required. The CMS review team also noted that the state did not have policies and procedures in place to effectively monitor and oversee

operations, the MCO contract, and the managed care program functions and corresponding units. In addition, systems, and policies and procedures were not in place at the DPI or in the Division of Internal Audits. The state does not utilize auditing tools or performance metrics to evaluate the MCOs; they also do not conduct onsite reviews to assess oversight of the MCOs' program integrity activities.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

South Carolina's MCO contract states, "The contractor shall have surveillance and utilization control programs and procedures in accordance with 42 CFR 456.3, 456.4, and 456.23, to safeguard Medicaid funds against unnecessary or inappropriate use of Medicaid services and improper payments." The Healthy Connections Choices contract also states, "The contractor (MCO) shall establish functions and activities, governing program integrity, in order to reduce the incidence of fraud, waste and abuse and shall comply with all state and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, 1128, 1902, 1903, and 1932; 42 CFR 431, 433, 434, 435, 438, 441, 447, 455; and 45 CFR Part 74."

The DPI developed a SharePoint site where each of the MCOs reports provider cases and other related monthly and quarterly reports; terminations for cause; suspension, exclusions, and terminations; and fraud referrals. According to the MCO contract, all fraud must be reported through the state's secure portal within one day.

The MCOs' SIUs conduct all preliminary and full investigations. If fraud is suspected, the MCO notifies their program integrity coordinator that a referral was transmitted to the state through the portal and the referral is recorded by a program integrity intake worker. Once the state's program integrity MCO coordinator and other appropriate program integrity staff determine a credible allegation of fraud exists, the case is referred to the MFCU for review, as required by the MCO contract

BlueChoice's SIU investigate cases of suspected fraud, waste, and abuse. The SIU reviews documentation and applies any investigative steps and/or administrative actions necessary. The SIU utilizes a database to track all provider and member fraud, waste, and abuse investigations; corresponding documentation; and all current and future rules and regulations. The investigative process normally takes up six months to complete.

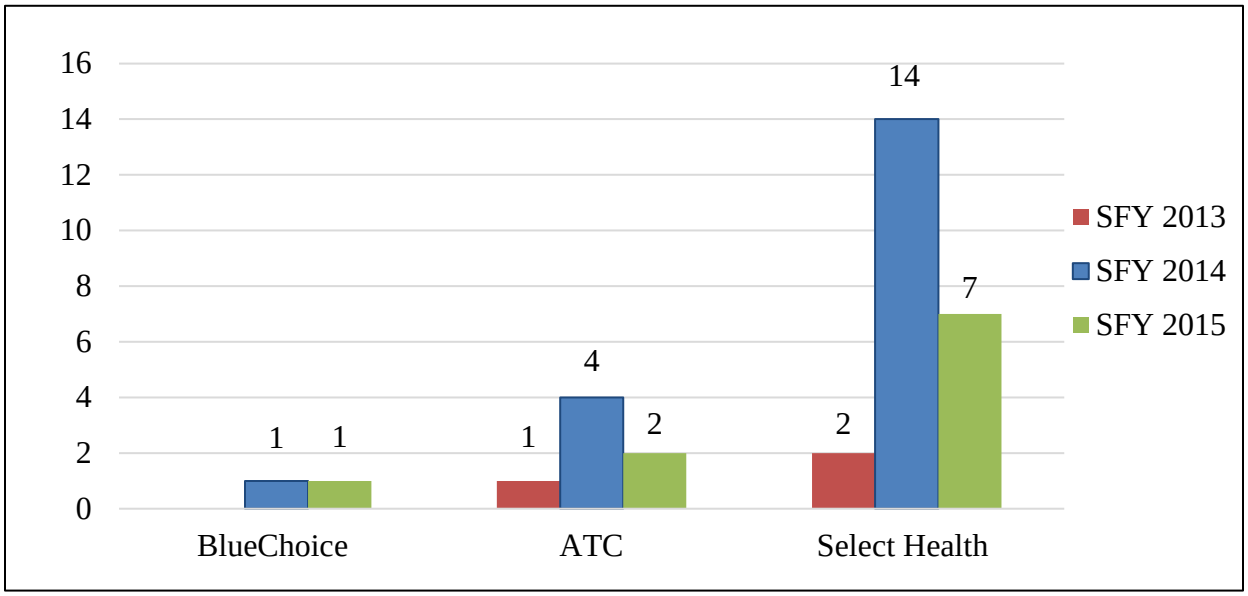
The ATC's SIU conducts a preliminary investigation within 30 working days of receipt of the case. If no fraud is suspected, the case is closed and tracked for future reference; the internal joint fraud, waste, and abuse group is also informed of the investigative results. If it is determined that a review of medical records is necessary, a full investigation is conducted. The SIU has 15 working days to select a medical records sample and send the request to the internal joint fraud, waste, and abuse group for review and approval. Upon approval, the SIU sends a

certified letter to the provider requesting the records. Once the medical records are received, the SIU reviews the medical records and discusses the results with Centene's medical director within 60 working days. If fraud, waste, or abuse is suspected after completion of the medical records review by the internal joint fraud, waste, and abuse group, Centene's SIU will process the case in accordance with SCDHHS's PIU policies and procedures for fraud referrals.

The Select Health SIU director assigns a specific deadline during which an investigator is expected to complete a particular investigative activity phase. When the decision has been made that a fraud referral to the MCO warrants a full investigation, the case is assigned to an investigator or investigative analyst. The typical target for investigative case completion is between four to six months from the date of assignment to the conclusion. The SIU utilizes a database to track these provider and member fraud and abuse investigations.

Table 3 lists the number of referrals that BlueChoice, ATC, and Select Health made to the state in the last three SFYs. Overall, the number of fraud referrals reported by the three SCDHHS MCOs is low, compared to the size of the plan, and the volume of monies overpaid to providers and identified for recovery during the past three SFYs.

Table 3.



*BlueChoice did not refer any investigations to the state during SFY 2013.

MCO Compliance Plans

The state does require its MCOs to have a compliance plan to guard against fraud, waste, and abuse in accordance with the requirements at 42 CFR 438.608.

The state does not have a process or written tool to review the compliance plans and programs. When asked to provide details regarding the means of monitoring and measurement, the state replied that it does review the compliance plans; however, no review process was explained to the CMS review team. The state does perform a general, high-level overview and validity check of the MCOs' compliance plans, but does not an in-depth review measurement, standards, and oversight purposes. The MCO coordinator for the PID is responsible for reviewing the MCOs' compliance plans annually.

As required by 42 CFR 438.608, the state does review the MCEs' compliance plans and communicate approval/disapproval with the MCEs. During the onsite interview, the program integrity MCO coordinator mentioned that a discrepancy was found in one of their MCO's compliance plan; the MCO was not identified. However, per the program integrity MCO coordinator, the issue did not prevent the clearance or result in disapproval of that particular MCO's compliance plan.

The MCO model contract does make compliance with 42 CFR 438.608 mandatory**.** All of the MCOs provided the CMS review team with a copy of their compliance plan submitted to the

state. A review of these plans revealed they were in compliance with 42 CFR 438.608. No notable issues were identified

Encounter Data

The SCDHHS stated that they review encounter data submitted by the MCOs. To conduct validation assessments, the SCDHHS requests that the MCOs provide medical records for enrollees and encounter reports from their administrative databases. In addition, the MCOs are required to provide a monthly attestation for all encounter data submitted. The MCOs' performance is also monitored through the review and analysis of reports to include the following: detailed encounter data, payment information, and services utilization. The monitoring process ensures complete and accurate reporting, and assists in reconciling encounter submissions. Encounter data submitted to the state may be reviewed for fraud, waste, and abuse; however, this analysis process is still in the developmental stages.

Overpayment Recoveries, Audit Activity, and Return on Investment

The state does not require MCOs to return to the state overpayments. However, the MCOs are required to report on overpayments recovered from providers resulting from MCO fraud and abuse investigations and audits. This provision is also addressed in *Section 11* of the MCO model contract. However, in cases where SCDHHS discovers that the MCO has submitted erroneous information, the state may also recover incentive payments. The SCDHHS's recovery of incentive payments may include both the MCO's and provider's portion of the incentive payment, and may include liquidated damages, as outlined in the MCO's contract.

The state requires the MCOs to submit a monthly report detailing the outcomes or results of the MCOs' program integrity efforts. The monthly report includes the amount of overpayments identified and recovered, and whether each MCO imposed any sanctions on providers based upon program integrity activities. These reports and other data elements are used in the rate setting process. The SCDHHS reviews the reports monthly for validity and accuracy, but does not systematically evaluate an MCO's program integrity performance.

In addition, the CMS review team also found that cost avoidance and prevention efforts referenced by the MCOs were neither tracked nor monitored by the state. Also, no cost avoidance parameters were established in the 2014 model contract.

The ATC and Select Health placed providers on prepayment review for more than a year without any administrative actions executed; prepayment review lasted between two to four years for some providers. Keeping providers on prepayment review for extended periods of time may result in cases not being opened in a timely manner and providers going unreported to the DPI.

The table below shows the respective amounts reported by BlueChoice for the past three SFYs.

Table 4-A.

SFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013*	0	0	$0	$0
2014	16	15	$824,522	$0
2015	23	6	$54,877	$927

*The MCO did not perform investigative or recovery activities during this SFY.

The table below shows the respective amounts reported by ATC for the past three SFYs.

Table 4-B.

SFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013*	31	24	$0	$0
2014	44	38	$80,568	$80,568
2015*	30	30	$0	$0

*The MCO's investigative activities did not result in any overpayments identified or recovered during this SFY.

The table below shows the respective amounts reported by Select Health for the past three SFYs.

Table 4-C.

SFY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2013*	19	16	$20,058	$0
2014	48	38	$1.1 million	$7,108
2015	55	44	$769,752	$10,939

*The MCO's program integrity activities did not result in any overpayments recovered during this SFY.

Overall, the volume of investigations conducted and overpayments recovered is low when considering the annual MCO expenditures. The MCOs' full investigative activity slightly increased over the three year review period reviewed. During the onsite interviews, low recoveries were attributed to proactive system edits and prepayment savings; however, no evidence of these activities was provided to the team. In addition, a significant amount of overpayments identified was identified as being engaged in litigation. Also, providers are voluntarily terminating their provider agreements, therefore prohibiting recovery of overpayments by the MCOs. Some of the MCOs restrict the overpayment look back period 18 months, which is a constraint that limits possible collections; this was the case with ATC.

Several ATC cases remained opened for an average time period of between one to two years. One complaint which transitioned into a retroactive review was opened on December 22, 2011; an overpayment of $11,265 was identified and the case was closed on November 30, 2015. No monies were collected and this case was reported to the state on December 28, 2012. During the

past three SFYs, ATC's overpayments identified and recovered were low, in comparison to the plan's expenditures.

Case investigation sampling identified a Select Health case that was opened on May 13, 2013, for a high level of prolonged physician visits was still open as of the CMS onsite review. An overpayment was identified for this case; however, the provider was instructed by the MCO to not send in a recoupment check, as it would be collected through offsetting future claims payments. The case was referred to the state on May 2, 2012, and still remained open at the time of the CMS onsite review. In addition, another Select Health case sampled involved a pediatric group practice and was opened on April 12, 2013, as a result of a claims review. Similar to the previous case, the provider was directed by the MCO not to send in a recoupment check, as it would be collected through offsetting future claims payments. The case remained open at the time of the date of the CMS onsite review.

Payment Suspensions

In South Carolina, Medicaid MCOs are contractually required to suspend payments to providers at the state's request. The state confirmed that there is contract language mirroring the payment suspension regulation at 42 CFR 455.23. Once the suspected case is received and investigated by the state's Division of Program Integrity unit, the determination of a credible allegation of fraud will be made. The SCDHHS contractually requires all MCOs to suspend provider payments until further notice or termination, for those cases identified with an allegation of fraud.

The state's process for payment suspensions is aligned with the regulation at 42 CFR 455.23. According to the federal regulation, the state Medicaid agency is responsible for determining if there is a credible allegation of fraud and consequently suspending provider payments, if warranted. After the provider's payments are suspended, the case is referred to the MFCU, unless the state exercises their good cause exception on the provider or law enforcement/MFCU requests the suspension of payments to the provider not be imposed.

Also, SCDHHS does report these suspensions to the Secretary; however, these suspensions are not always reported in a timely fashion, as required in 42 CFR 455.23. The state informed the CMS review team that the annual reports for suspensions occurring from 2014 and 2015 were filed in May 2016. Once provider payments are suspended, notification of these suspensions must be reported annually to the Secretary, according to the regulation.

Terminated Providers and Adverse Action Reporting

The state MCO contract states that the MCO may terminate the provider or take adverse action without SCDHHS approval; however, the MCO is required to notify the SCDHHS regarding terminations or adverse actions taken against a provider. The MCO model contract does not contain language defining the timeframe for reporting these terminations; they may be reported to the state either prior to or after the provider has been terminated. This applies to all types of terminations and administrative actions including terminations for cause. Each MCO reports

providers terminated for cause to the state Medicaid agency monthly, using the *Monthly Termination/Denial for Cause Report Form*.

In addition, the MCOs check the state's website to see if SCDHHS has taken any previous administrative actions or terminations. All of the MCOs respectively follow the same process contained in the 2014 MCO Healthy Connections Choices contract. However, SCDHHS does not require their MCOs to report problem providers that do not have their contracts renewed due to for cause reasons.

Table 5.

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed SFYs		Total # of Providers Terminated For Cause in Last 3 Completed SFYs	
BlueChoice	2013 2014 2015	299 415 713	2013 2014 2015	6 3 0
ATC	2013 2014 2015	206 299 33	2013 2014 2015	25 7 4
Select Health	2013 2014 2015	249 299 340	2013 2014 2015	8 9 4

Overall, the number of providers terminated for cause by the plans appears to be low, compared to the number of providers in each of the MCOs' networks and compared to the number of providers disenrolled or terminated for any reason. The state cited contributing factors to these low numbers of for cause terminations include the lack of reporting of terminations for cause by the MCOs and not renewing their providers' contracts when the contract has reached expiration. Currently, the state is not sharing this information with other states or the other plans. However, some of the MCOs do share this information with other MCOs.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider or persons with an ownership or control interest in the provider, and agents and managing employees of the provider against the U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG) List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration's Death Master File (SSA-DMF); the National Plan and Provider Enumeration System upon enrollment and reenrollment, and check the LEIE and EPLS no less frequently than monthly.

The SCDHHS enrolls all Medicaid and Medicaid managed care providers. Managed care providers participating in any MCO are required to be enrolled in South Carolina's Medicaid program, before they can enroll in any one of the six MCOs.

During onsite interviews, the CMS review team confirmed that the state is checking all of the federal databases as required at 42 CFR 455.436, at the appropriate intervals. In addition, the state also contractually requires their MCOs to perform the federal databases checks. However, the CMS review team noted that BlueChoice is not checking owner and managing employees against the databases, nor are they checking the SSA-DMF.

Recommendations for Improvement

- The SCDHHS should ensure the MCOs build SIUs with sufficient resources and staffing commensurate with the size of their managed care programs to conduct the full range of program integrity functions including the review, investigation, and auditing of provider types where Medicaid dollars are most at risk.
- The SCDHHS should ensure that their levels of staffing are adequate to conduct all necessary program integrity activities. Although the DPI referred to other staffing resources available to assist with program integrity operations, activities, and contract performance, the state should have adequate staff dedicated to conducting the required program integrity activities and not be dependent upon staff from other areas, when vacancies occur.
- The SCDHHS should conduct MCO onsite visits at least once a year. Regular onsite visits would provide increased oversight by the state Medicaid agency.
- The state should develop written policies and procedures to effectively monitor and oversee operations, the MCO contract, and the managed care program functions and corresponding units.
- The state should conduct annual, in-depth reviews of the implementation of the MCOs' compliance plan. In addition, the state should develop written process to review the compliance plans and programs, including parameters for monitoring and measurement. The state should also consider incorporating language in its MCO model contract to make compliance with 42 CFR 438.608 mandatory.
- The state and the MCOs should work together to strengthen parameters regarding prepayment rules, policies, and requirements. The length of time that providers remain on prepayment should be evaluated with regard to the effectiveness and resources allocated to monitoring providers over an extended duration.
- The state should obtain evidence from its MCOs in support of any statements attributing a decline in overpayments as the direct result of cost avoidance activities or proactive measures in place. Some tangible examples of cost avoidance include a walk-through of the Medicaid Management Information System edits; written policies and procedures specifically addressing cost avoidance activities; documentation from contractors regarding measures instituted and resulting in cost avoidance; screenshots, documentation, tracking spreadsheets, samples, etc. from systems that demonstrate cost avoidance measures; or an explanation of any methodology employed that has resulted in deterring overpayments to providers.
- The state should consider amending the MCO contract to include a look back and/or overpayment collection period of greater than 18 months. Increasing the time look back period removes the short period time constraint that limits possible collections
- The state should increase monitoring, tracking, and reporting parameters for open cases where overpayments have been identified, but no monies have been collected. Increased oversight of the investigative and overpayment processes improves the potential for recoveries for cases that have remained opened over extended time periods with overpayments identified and not recouped.
- The state should ensure that all payment suspensions implemented against MCO and FFS providers are reported annually to the Secretary per 42 CFR 455.23 (g)(3).

- The state should include language in its contract defining the timeframe for reporting provider terminations.
- The SCDHHS should incorporate language requiring their MCOs to report problem providers that do not have their contracts renewed due to for cause reasons to the state.
- The state should ensure that the MCOs are downloading and checking the monthly Medicare revocation list from TIBCO. In addition, the state should also consider providing the downloaded TIBCO list of terminated providers to their MCOs to assist in identifying providers who should be terminated from the plans' networks and to decrease reliance on disenrollment as the primary method for removal of terminated providers. The state should ensure that terminated providers are being forwarded for entry into the TIBCO system.
- The state should ensure that the MCOs are performing all required federal database checks for the organization (42 CFR 455.436) and for all others required (42 CFR 438.610) at the appropriate time intervals specified in the regulations.

Section 2: Status of Corrective Action Plan

South Carolina's last CMS program integrity review was in January 2011, and the report for this review was issued in October 2011. The report contained two findings and seven vulnerabilities. During the onsite review in May 2016, the CMS review team conducted a review of the corrective actions taken by South Carolina to address all issues reported in calendar year 2011. The findings of this review are described below.

Findings -

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

   Status at the time of the review: Corrected

   All required disclosure information on ownership, control, and relationships from disclosing entities and subcontractors is now captured on the state's additional disclosure form which providers are required to sign. The state provided a copy of this document to the CMS review team.

2. ***The state does not report all adverse actions taken on the provider applications to the U.S. Department of Health and Human Services – Office of the Inspector General (HHS-OIG).***

   Status at the time of the review: Corrected

   The state provided the CMS review team with a copy of the most recent two adverse action reports submitted to the HHS-OIG to demonstrate ongoing compliance.

Vulnerabilities -

1. ***Limited state oversight of MCE program integrity activities.***

   Status at the time of the review: Not corrected

   The oversight issues related to minimal reporting obligations; limited interaction with plan personnel; lack of training activities; the need to improve communication and collaboration between the MCOs and the MFCU; and managed care and program integrity are still not fully corrected. However, the state is working to resolve these issues.

   The state still needs to enhance its oversight reporting issues, including but not limited to greater use of available tools to identify issues of MCO oversight, and review of aging investigations or prepayment reviews. Having the state conduct reviews of the plans and create performance metrics will improve the return on investment. Also, the state should require that MCOs report those providers dropped or not renewed in their networks.

2. Not collecting full ownership and control disclosure information from NEMT and managed care providers.

Status of Review: Corrected

Previously, the state utilized *Form 1514* to capture full ownership and control disclosures for the NEMT and MCO providers. However, NEMT enrollment was not required to use this form and these disclosures were not captured.

The state now requires both the NEMT and managed care providers to utilize either *Form 1514* (for MCOs) or *NEMT Form 1514* to capture full ownership and control disclosure information.

3. Not requiring the disclosure of business transaction information upon request in MCO and NEMT provider agreements.

Status at the time of the review: Corrected

Both *Form 1514* and the *South Carolina Uniform Managed Care Provider Credentialing Application* now contain language requiring the disclosure of business transaction information for both NEMT and MCO providers, per 42 CFR 455.104.

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

Status at the time of the review: Corrected

Previously, NEMT providers were not required to complete *Form 1514* which captures criminal convictions. In addition, the language in Section VII of *Form 1514* did not request the disclosure of criminal offenses related to involvement in programs established by the *Social Security Act Title XX*, as required by 42 CFR 455.106. The state now utilizes a separate form specifically for NEMT providers.

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

   Status at the time of the review: Corrected

   The provider applications for both the NEMT and MCO programs have been amended to include the reporting of adverse actions to SCDHHS.

6. ***Not conducting complete searches for individuals and entities excluded from participating in Medicaid-SMDL #08-003 and #09-001 (exclusion checks) for the Medicaid agency, MCEs, MCE providers, and NEMT brokers.***

   Status at the time of the review: Corrected

   The state currently conducts monthly searches of all required federal databases at the appropriate frequency. Monthly exclusion checks are performed for institutional and non-institutional providers and contractors, such as their MCO and NEMT brokers.

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

   Status at the time of the review: Corrected

   To verify services rendered, the state mails an explanation of medical benefits (EOMBs) to 400 randomly sampled Medicaid beneficiaries. The EOMBs list all FFS and/or managed care services paid to the MCO network providers on their behalf.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for South Carolina to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute, which can help address the risk areas identified in this report. Courses that may be helpful to South Carolina and based on its identified risks include those related to managed care. More information can be found at http://www.justice.gov/usao/training/mii/.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf.

Conclusion

The CMS focused review, identified areas of concern and an instance of non-compliance with federal regulations, which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction 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 CAP 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 the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

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

Healthy Connections MEDICAID

Henry McMaster GOVERNOR
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July 20, 2017

Laurie Battaglia
Director Division of State Program Integrity
Center for Medicare & Medicaid Services
7500 Security Blvd, Mail Stop AR-21-55
Baltimore, MD 21244

Sent via email: Laurie Battaglia@cms.hhs.gov
Re: State of South Carolina – Focused MCO Program Integrity Review
Final Report Date: June 2017

Dear Ms. Battaglia,
The South Carolina Department of Health and Human Services (The Department) is submitting its response to the Department of Health and Human Services Centers for Medicare and Medicaid Services Center for Program Integrity's final report. Attached please find a corrective action plan for each of the final report's recommendations.

We acknowledge your request that the Department provide quarterly reports to CMS detailing the number of provider investigations conducted by each of our MCOs, as well as the number of suspected fraud referrals provided to the Department by the MCOs. We will send these quarterly reports to the Division of State Program Integrity beginning September 2017.

If you have any questions, please contact Betsy Corley, Division of Program Integrity, by email at Keyel@scdhhs.gov or phone at 803-898-1885.

Sincerely,

Deirdra T. Singleton

Acting Director