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South Carolina Medicaid Fraud Control Unit: 2020 Inspection

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Report in Brief

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Unit Case Outcomes

Federal fiscal years (FYs) 2018-2020

- 83 indictments
- 47 convictions
- 40 civil settlements and judgments
- $27,950,829 in total recoveries

Unit Snapshot

The South Carolina Medicaid Fraud Control Unit (MFCU or Unit) is part of the South Carolina Office of the Attorney General.

At the time of our inspection in January 2021, the Unit was approved for 17 staff, employed 13, and had 4 vacancies. The MFCU staff—6 investigators (including the chief investigator and the nurse investigator), 4 attorneys (including the director and deputy director), 1 auditor, and 2 support staff—are located in Columbia, South Carolina.

What OIG Found

We found that the South Carolina MFCU successfully investigated and prosecuted cases of Medicaid fraud and patient abuse or neglect when compared to MFCUs with similar staff sizes. We also observed that the Unit's State and Federal partners reported positive, cooperative relationships and held the South Carolina MFCU in high respect. For FYs 2018–2020, we identified six areas in which the Unit should improve its adherence to program standards and/or requirements.

We found that low staff levels and significant turnover contributed to large caseloads for Unit staff. We also found that in 16 percent of the Unit's case files, the Unit did not document the reason for significant investigative delays. Further, the Unit's case management system posed challenges for retrieving case information, and the Unit did not consistently document periodic supervisory reviews in its case files.

Additionally, we found that the Unit did not consistently report convictions or adverse actions to Federal partners within the appropriate timeframes consistent with regulatory requirements. We also found that the Unit's memorandum of understanding (MOU) with the State Medicaid agency generally reflected current practice, policy, and legal requirements with the exception of a regulatory requirement regarding procedures for the receipt of managed care referrals.

We also made observations regarding Unit operations and practices, including a beneficial practice employed by the Unit that may serve as a model for other Units: Unit management notified referral sources of the Unit's decision to open formal investigations of incoming referrals.

What OIG Recommends

To address these six findings, we recommend that the Unit (1) assess the adequacy of existing staffing levels, and if appropriate, consider a plan to expand the size of the Unit; (2) take steps to reduce investigation delays and ensure that the reasons for delays are documented in the case files; (3) seek approval from the South Carolina Office of the Attorney General to implement a new case management system; (4) take steps to ensure that supervisory reviews of Unit case files are conducted periodically and documented in accordance with Unit policy; (5) take steps to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes; and (6) revise the Unit's MOU with the State Medicaid agency to establish procedures by which the Unit will receive referrals of potential fraud from managed care organizations. The Unit concurred with all six recommendations.

TABLE OF CONTENTS

BACKGROUND

Objectives

To examine the performance and operations of the South Carolina Medicaid Fraud Control Unit (MFCU or Unit).

Medicaid Fraud Control Units

MFCUs investigate (1) Medicaid provider fraud and (2) patient abuse or neglect in facility settings and prosecute those cases under State law or refer them to other prosecuting offices.[1, 2, 3] Under the Social Security Act (SSA), a MFCU must be a "single, identifiable entity" of State government, "separate and distinct" from the State Medicaid agency, and employ one or more investigators, attorneys, and auditors.[4] Each State must operate a MFCU or receive a waiver.[5]

Currently, 50 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands operate MFCUs.[6] Each Unit receives a Federal grant award equivalent to 90 percent of total expenditures for new Units and 75 percent for all other Units.[7] In Federal fiscal year (FY) 2020, combined Federal and State expenditures for the Units totaled approximately $306 million, with a Federal share of $229 million.[8]

[1] SSA § 1903(q)(3). Regulations at 42 CFR § 1007.11(b)(1) clarify that a Unit's responsibilities include the review of complaints of misappropriation of patients' private funds in health care facilities.

[2] As of December 27, 2020, MFCUs may also receive Federal financial participation to investigate and prosecute abuse or neglect of Medicaid beneficiaries in a noninstitutional or other setting. Consolidated Appropriations Act, 2021, Public Law 116-260, Division CC, Section 207.

[3] References to "State" in this report refer to the States, the District of Columbia, and the U.S. territories.

[4] SSA § 1903(q).

[5] SSA § 1902(a)(61).

[6] The territories of American Samoa, Guam, and the Northern Mariana Islands have not established Units.

[7] SSA § 1903(a)(6). For a Unit's first 3 years of operation, the Federal Government contributes 90 percent of funding, and the State contributes 10 percent. Thereafter, the Federal Government contributes 75 percent and the State contributes 25 percent.

[8] OIG analysis of MFCUs' FY 2020 reporting of expenditures. The Federal FY 2020 was from October 1, 2019, through September 30, 2020.

OIG Grant Administration and Oversight of MFCUs

The Office of Inspector General (OIG) administers the grant award and provides oversight for each of the Units.[9, 10] OIG conducts a desk review of each Unit as part of an annual recertification process. OIG also conducts periodic inspections or reviews of selected Units. Finally, OIG provides ongoing training and technical support to the Units.

In its annual recertification review, OIG examines the Unit's reapplication materials, case statistics, and questionnaire responses from Unit stakeholders. Through the recertification review, OIG assesses the Unit's performance, as measured by the Unit's adherence to published performance standards;[11] the Unit's compliance with applicable laws, regulations, and OIG policy transmittals;[12] and the Unit's case outcomes.

OIG further assesses Unit performance by conducting inspections or reviews of selected Units. These inspections and reviews result in public reports of findings and recommendations for improvement. In the reports, OIG may also include observations regarding Unit operations and practices, including beneficial practices that may be useful to share with other Units.

In addition, OIG provides training and technical assistance to Units, as appropriate, both during inspections and reviews and on an ongoing basis. For example, during inspections and reviews, OIG assesses Units' case management systems, investigative procedures, and training needs and offers practical suggestions to address the Units' needs.

South Carolina MFCU

The South Carolina Unit is located in Columbia and is part of the South Carolina Office of the Attorney General. At the time of our inspection in January 2021, the Unit employed 13 staff—6 investigators (including 1 chief investigator and 1 nurse investigator), 4 attorneys (including the Unit director and deputy director), 1 auditor, and 2 support staff. Three investigator positions and one attorney position were vacant at the time of our inspection.

[9] As part of grant administration, OIG receives and examines financial information from Units, such as budgets and quarterly and final Federal Financial Reports that detail MFCU income and expenditures.

[10] The SSA authorizes the Secretary of Health and Human Services to award grants (SSA § 1903(a)(6)) and to certify and annually recertify the Units (SSA § 1903(q)). The Secretary delegated these authorities to OIG in 1979.

[11] MFCU performance standards are published at 77 Fed. Reg. 32645 (June 1, 2012) and appear online at https://oig.hhs.gov/authorities/docs/2012/PerformanceStandardsFinal060112.pdf. The performance standards were developed by OIG in conjunction with the MFCUs and were originally published at 59 Fed. Reg. 49080 (Sept. 26, 1994).

[12] OIG occasionally issues policy transmittals to provide guidance and instruction to MFCUs. Policy transmittals are located at https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/index.asp.

Referrals

The Unit receives referrals in various forms, including by email, telephone, and mail. During the inspection period, the Unit had different approaches for the review and assignment of those allegations involving fraud and those involving patient abuse or neglect.[13]

All incoming fraud referrals were subject to review by the Unit's Provider Fraud Intake Committee which consisted of the director, deputy director, chief investigator, auditor, and investigative analyst.[14] The committee held weekly meetings to review each fraud referral and determine whether to (1) assign the referral to a team, (2) defer it until the Unit could obtain additional information to properly evaluate the referral, or (3) decline it for investigation and notify the referring party of the Unit's decision, as appropriate.

In contrast, when the Unit received referrals of patient abuse or neglect, it directed the referrals to the Unit's auditor, who conducted an initial review of each referral to determine whether additional information was needed. After gathering any additional information, the auditor either (1) notified the referring party, in consultation with the Unit deputy director, that the Unit would not take action; or (2) forwarded the referral to the Unit director and deputy director, with a recommendation to open an investigation. The director or deputy director would then review the auditor's recommendation and determine whether to open an investigation, and if so, assign a team to the case.

Investigations and Prosecutions

During our review period, the Unit's assigned investigative teams consisted of one or more investigators; one or more attorneys; an auditor; an administrative assistant; and, if beneficial to the case, a nurse investigator. After the Unit opened a case and assigned it to a team, the investigator, in consultation with the team, devised an investigative plan to guide the investigation. At the request of the team, additional investigators and/or support staff could be assigned to the case.

Once the team determined that a case had been thoroughly investigated, the team met with the director or deputy director to recommend proceeding with a criminal, civil, or administrative resolution or, as appropriate, closing the investigation. The director would then approve a course of action such as additional investigation, criminal prosecution, or civil recovery. Alternatively, the director could decline

[13] At the time of our inspection, the Unit was in the process of revising its referral intake procedures to establish a uniform process for reviewing and assigning allegations involving fraud and those involving patient abuse or neglect.

[14] At the Director's discretion, a referral may be immediately opened as a case without intake committee review.

prosecution and instead refer the case to the State Medicaid agency or to another appropriate agency.

South Carolina Medicaid Program

The South Carolina Department of Health and Human Services (SCDHHS) administers the State Medicaid program. In FY 2019, approximately 77 percent of South Carolina's 1,058,406 Medicaid beneficiaries were enrolled in a Medicaid managed care plan.[15, 16] In FY 2020, South Carolina's Medicaid expenditures were $7.03 billion.[17]

The SCDHHS Bureau of Compliance and Performance Review includes the Medicaid program's Program Integrity Division, whose mission is to safeguard the Medicaid program against fraud, waste, and abuse.

Prior OIG Report

OIG conducted a previous onsite review of the South Carolina Unit in 2011.[18] In that review, which covered FYs 2008–2010, OIG found that (1) the Unit's caseload increased by 65 percent, and the amount of funds the Unit recovered nearly doubled; (2) although almost all case files contained documentation of supervisory approval to open and close cases, 61 percent contained no documentation of periodic supervisory reviews; (3) the Unit had not updated its policies and procedures manual or its memorandum of understanding (MOU) with SCDHHS; and (4) the Unit maintained proper fiscal control of its resources, but it did not report program income properly in FY 2010.

OIG recommended that the Unit (1) ensure that periodic supervisory reviews are documented in Unit case files; (2) complete revisions to its policies and procedures manual to reflect current Unit operations, and revise its MOU with SCDHHS to reflect current law and practice; and (3) ensure that program income is reported properly. On the basis of information received from the Unit in 2013, OIG considered the recommendations implemented.

[15] *Kaiser Family Foundation, Total Monthly Medicaid/CHIP Enrollment and Pre-ACA Enrollment*, September 2019, https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=14&selectedRows=%7B%22states%22:%7B%22south-carolina%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed on February 18, 2021.

[16] *Kaiser Family Foundation, A View from the States: Key Medicaid Policy Changes*, October 2019, http://files.kff.org/attachment/Report-A-View-from-the-States-Key-Medicaid-Policy-Changes. Accessed on February 18, 2021.

[17] OIG, *MFCU Statistical Data for FY 2020*, https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2020-statistical-chart.pdf. Accessed on March 19, 2021.

[18] OIG, *South Carolina State Medicaid Fraud Control Unit: 2011 Onsite Review*, https://oig.hhs.gov/oei/reports/oei-09-11-00610.pdf. Accessed on December 9, 2020.

Methodology

We conducted an inspection of the South Carolina MFCU in January 2021. Because of the COVID-19 pandemic, the OIG team conducted the inspection remotely using a virtual format. Our inspection covered the 3-year period of FYs 2018–2020. We based the inspection on an analysis of data and information from 6 sources: (1) Unit documentation, such as policies and procedures; (2) financial documentation; (3) structured interviews with key stakeholders; (4) structured interviews with Unit managers and selected staff; (5) a review of a random sample of 88 case files from the 464 nonglobal case files that were open at some point during the review period; and (6) review of all convictions submitted to OIG for program exclusion and all adverse actions submitted to the National Practitioner Data Bank (NPDB) during the review period. See the Detailed Methodology beginning on page 22 of this report.

In examining the Unit's operations and performance, we applied the published MFCU performance standards, but did not assess adherence to every performance indicator for each of the 12 performance standards.

Standards

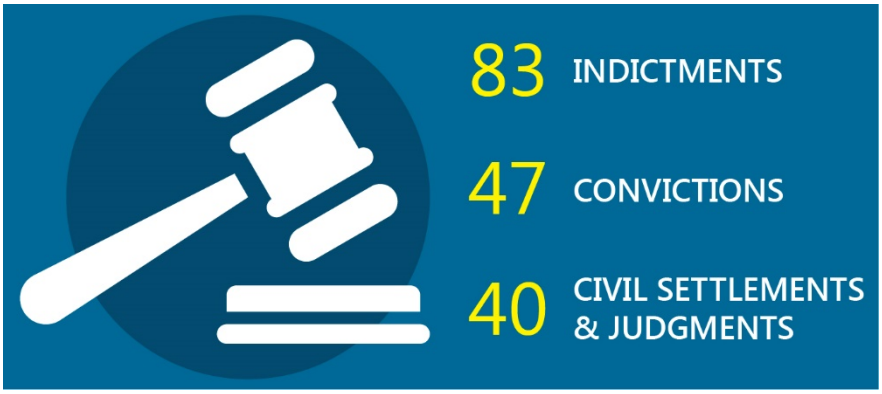
We conducted this inspection in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency. These inspections differ from other OIG evaluations in that they support OIG's direct administration of the MFCU grant program, but they are subject to the same internal quality controls as are other OIG evaluations, including internal and external peer review.

PERFORMANCE ASSESSMENT

Below are the results of OIG's assessment of the performance and operations of the South Carolina MFCU. We identified the Unit's case outcomes; evaluated whether the Unit complied with legal requirements; and, for each of the performance standards, made finding(s) and/or observation(s), including highlighting a beneficial practice. We found that the South Carolina MFCU successfully investigated and prosecuted cases of Medicaid fraud and patient abuse or neglect when compared to MFCUs with similar staff sizes. We also observed that the Unit's State and Federal partners reported positive, cooperative relationships and held the South Carolina MFCU in high respect. We found six areas in which the Unit should improve its adherence to program standards and/or requirements.

CASE OUTCOMES[19]

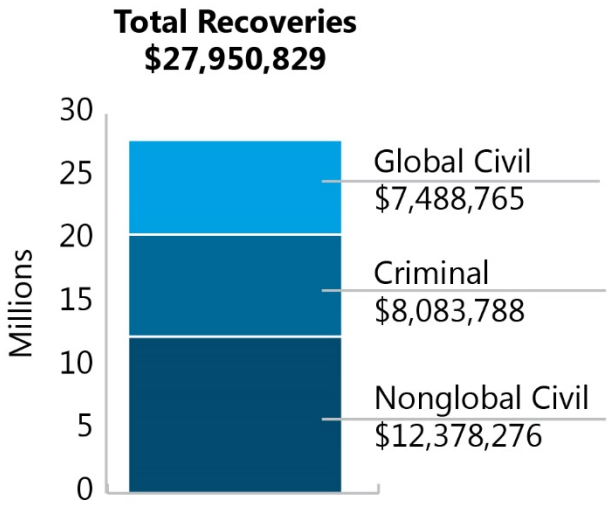
The Unit reported 83 indictments, 47 convictions, and 40 civil settlements and judgments for FYs 2018–2020. Of the 47 convictions, 29 convictions involved patient abuse or neglect and 18 convictions involved Medicaid provider fraud.



The Unit reported total recoveries of $28 million for FYs 2018–2020. (See Exhibit 1 for the sources of those recoveries.)

[19] OIG provides information on MFCU operations and outcomes, but it does not direct or encourage MFCUs to investigate or prosecute a specific number of cases. MFCU investigators and prosecutors should apply professional judgment and discretion in determining what criminal and civil cases to pursue.

Exhibit 1: The Unit reported combined civil and criminal recoveries of $28 million (FYs 2018–2020).



Source: OIG analysis of Unit statistical data, FYs 2018–2020.

Note: "Global" civil recoveries derive from civil settlements or judgments in global cases, which are cases that involve the U.S. Department of Justice and a group of State MFCUs and are facilitated by the National Association of Medicaid Fraud Control Units.

STANDARD 1	A Unit conforms with all applicable statutes, regulations, and policy directives.

Observation

From the information we reviewed, the South Carolina Unit did not comply with two applicable legal requirements. We identified one compliance concern related to the Unit's reporting of convictions and adverse actions to Federal partners, as explained in the finding under Performance Standard 8 below, and one compliance concern related to a Federal regulation regarding its MOU with the State Medicaid agency, as explained in the finding under Performance Standard 10 below.

STANDARD 2	A Unit maintains reasonable staff levels and office locations in relation to the State's Medicaid program expenditures and in accordance with staffing allocations approved in its budget.

Finding

Low staff levels and significant turnover contributed to large caseloads for Unit staff. According to Performance Standard 2(b), the Unit should employ a total number of professional staff that enables the Unit to effectively investigate and prosecute (or refer for prosecution) an

appropriate volume of case referrals and workload for both Medicaid fraud and patient abuse and neglect. We found that (1) the Unit's staff levels were low in relation to the State's Medicaid program expenditures; (2) low staff size and high turnover contributed to large caseloads for Unit staff; and (3) low MFCU staff salaries led to significant turnover among management and staff.

The Unit's staff levels were low in relation to the State's Medicaid program expenditures. At the end of FY 2020, the Unit was approved for 17 staff and employed 14 staff; by the time of our inspection in January 2021, the Unit employed 13 staff.[20] In FY 2020, South Carolina's Medicaid expenditures were $7.03 billion. We found that the Unit's staff size was low compared to that of all other MFCUs relative to the respective States' Medicaid program expenditures. While we did not find specific evidence that the limited staff size negatively affected the Unit's case outcomes, Unit managers expressed concerns that the Unit did not have enough staff to effectively investigate and prosecute the volume of case referrals received by the Unit.

Unit investigators and other staff carried large caseloads. Unit managers and staff reported, and we concluded, that the caseloads for Unit investigators and other staff were too large. One manager described the caseloads as "discouraging" to Unit staff and negatively affecting morale and the timeliness of casework. See Exhibit 2 for the caseloads for Unit investigators, attorneys, and the auditor at the time of our inspection.

Exhibit 2: Staff Caseloads for Unit Investigators, Attorneys, and Auditor

*Note: At the time of our inspection, the Unit's newest investigator, hired in November 2020, was assigned to 7 cases. All other investigators carried between 18-52 cases. The median caseload for all Unit investigators was 35.

Source: South Carolina MFCU, January 2021.

[20] At the time of our inspection, the Unit was taking steps to fill the three vacancies.

We also found that the Unit's chief investigator and director, in addition to having supervisory responsibilities, carried large caseloads. At the time of our inspection, the chief investigator had 42 cases, and the director had 74 cases. In OIG's experience, it is unusual for investigative and attorney supervisors to carry large caseloads while also having managerial duties. In OIG's judgment, depending on the complexity of the particular cases, carrying caseloads of this magnitude can lead to investigative delays, and staff with such caseloads may not adequately document their cases.

Unit staff reported that low MFCU staff salaries led to significant turnover among Unit staff. Although the Unit's staff levels remained relatively consistent during the review period (16 staff at the ends of FYs 2018 and 2019; 14 staff at the end of FY 2020; and 13 staff at the time of our inspection in January 2021), the Unit experienced significant staff turnover. During the 3-year review period, 5 employees left the Unit, including 2 attorneys, 1 of whom was the Unit director; 2 investigators; and 1 auditor. In the 3 months following the end of the review period (September 30, 2020) and our inspection in January 2021, 4 more investigators, including the chief investigator, left the Unit.[21] Additionally, the Unit's auditor resigned in February 2021, subsequent to our inspection.

Unit managers and staff attributed the high turnover to the low salaries available to South Carolina State employees, explaining that many experienced staff left the Unit for more competitive salaries in the private sector. For example, in FY 2020, the base salaries for Unit investigators ranged between $48,867 and $61,200.[22] One Unit manager reported that State managed care organizations (MCOs) had offered some MFCU investigators positions with the MCO with salaries that were $25,000-$30,000 greater than the Unit's salaries for those investigators. Managers and staff described the salaries of Unit employees as an obstacle to hiring and retaining qualified staff. Unit managers expressed concern that given the current salaries, the Unit will likely continue to lose talented staff to the private sector and to higher-paying government jobs.

[21] The Unit hired two staff members—one attorney and one investigator—between October 1, 2020, and our inspection in January 2021.

[22] OIG compared the FY 2020 salaries of South Carolina Unit professional staff to those of professional Unit staff in the neighboring States of Georgia and North Carolina. OIG found that attorneys in the South Carolina Unit earned base salaries between $53,550 and $68,454 (except for one senior attorney who earned $100,440), while attorneys in the North Carolina and Georgia Units earned between $78,849 and $143,211. Investigators at the South Carolina MFCU had a higher starting salary than in the two neighboring States, but earned base salaries between $48,867 and $61,200, compared to investigators in the North Carolina and Georgia Units who earned base salaries between $41,291 and $113,334. The auditor in the South Carolina Unit earned a base salary of $63,240, while auditors in the North Carolina and Georgia Units earned base salaries between $42,840 and $84,389. In our analysis, we did not examine the wider labor market for attorneys, investigators, and auditors in the three States.

In January 2016, a contractor hired by the South Carolina Department of Administration, Human Resources Division, issued a report detailing a review of the State's employee classification and compensation plan. The review found that South Carolina State employee salaries were uncompetitive, lagging behind those of other States by an average of 15 percent and behind those in South Carolina's private sector by 18 percent. The report acknowledged that the uncompetitive salaries created challenges in both recruitment and retention of qualified State employees. The report recommended that the South Carolina Human Resources Division adjust pay ranges to be consistent with the labor market and create a more consistent approach to performance-based pay. As a result, in December 2020, State Representative Gilda Cobb-Hunter sponsored a bill proposing to direct the Human Resources Division to implement the study's recommendations and to increase State employee salaries to account for inflation.[23] The bill was referred to the South Carolina House Committee on Ways and Means in January 2021.

In interviews, Unit managers explained that the departures of Unit investigators and attorneys negatively affected the efficiency and timeliness of Unit casework because cases needed to be reassigned, and newly assigned staff needed time to become familiar with the cases. Unit managers also stated that managers and staff carried large caseloads that were unsustainable because, with each turnover in staff, cases were reassigned to individuals who were already carrying full caseloads. Further, one manager explained that the increased caseloads caused by the turnover left some Unit staff "overworked," which made them more likely to seek or accept higher-paying jobs elsewhere.

STANDARD 3	A Unit establishes written policies and procedures for its operations and ensures that staff are familiar with, and adhere to, policies and procedures.

Observation

The Unit maintained written policies and procedures. The Unit maintained a Medicaid Fraud Control Unit Policies and Procedures Manual. The policies and procedures were electronically available to MFCU employees.

STANDARD 4	A Unit takes steps to maintain an adequate volume and quality of referrals from the State Medicaid agency and other sources.

Observations

The Unit took steps to encourage referrals from the State Medicaid agency and additional referral sources. To encourage referrals, the Unit

[23] A.B. 3342, House, 124 Reg. Sess. (SC 2021).

attended monthly meetings with the State Medicaid agency and bimonthly meetings with staff from the State Medicaid agency and MCOs to discuss topics such as referrals and the status of investigations. During the meetings, the Unit also provided training on what constitutes a quality referral. Additionally, the Unit maintained a toll-free hotline and an email address that the public could use to report potential provider fraud and/or patient abuse or neglect. Further, to increase awareness of the Unit, the Director provided presentations to the State Department of Aging regarding the mission of the MFCU and also presented at the Medicaid Program Integrity Institute on the topic of "Working with Your MFCU."

During the review period, the Unit received a total of 478 case referrals, of which 404 resulted in formal investigations. Appendix A includes Unit referrals by source for FYs 2018–2020.

Beneficial Practice

Unit management notified referral sources of the Unit's decision to open formal investigations of incoming referrals. We identified as a beneficial practice the Unit's high level of communication with the State Medicaid agency and other referral sources regarding the Unit's decision to accept or decline referrals. Through secure electronic communications, and as appropriate and permissible given the circumstances of each referral, the Unit routinely notified the Medicaid agency and other referring agencies of the Unit's decision to formally investigate fraud referrals submitted to the Unit.

Unit management also notified the referring agency and the State Medicaid agency's Program Integrity Division when the Unit decided not to formally investigate fraud referrals made to the Unit. For referrals received from private citizens, including referrals received through the Unit's hotline, the Unit, on a case-by-case basis, also notified the individual who made the referral of the Unit's decision not to formally investigate the matter. When the Unit decided not to open a formal investigation for referrals of patient abuse or neglect, the Unit established a general practice of notifying the referring family member, facility, or regional ombudsman's office as appropriate. Further, the Unit also made efforts to notify referral sources when the Unit lacked jurisdiction over the matters alleged in a referral and referred matters to other law enforcement agencies or regulatory entities.

State Medicaid agency management lauded the Unit's communication regarding referrals and resulting investigations as "a good practice," stating that Unit staff were "very responsive" and "open to back and forth" communication. Additionally, officials from the State Long-Term Care Ombudsman's office stated that the Unit's response to referrals was encouraging and that frequent communication and feedback from the Unit regarding referrals was "wonderful."

STANDARD 5	A Unit takes steps to maintain a continuous case flow and to complete cases in an appropriate timeframe based on the complexity of the cases.

Observation

All case files contained documentation of supervisory approval to open and, as appropriate, supervisory approval to close. According to Performance Standard 5(b), supervisors should approve the opening and closing of all investigations, review the progress of cases, and take action as necessary to ensure that each stage of the investigation and prosecution is completed within an appropriate timeframe. We found that all of the sampled case files contained documentation of supervisory approval to open, and as appropriate, supervisory approval to close. See Appendix B for the point estimates and the confidence intervals for the case file reviews.

Finding

In 16 percent of the Unit's case files, the Unit did not document the reason for significant investigative delays. Performance Standard 5(c) states that delays in investigation and prosecution should be "limited to situations imposed by resource constraints or other exigencies." We found that 16 percent of the Unit's investigations had significant delays that were not explained in the case file. The unexplained delays ranged from approximately 6 to 18 months. The Unit attributed the unexplained delays to resource constraints related to staff turnover and large caseloads. The Unit also noted that some delays that occurred in the spring and summer of 2020 resulted from COVID-19-related restrictions in the State. Unit management explained that for some cases, the causes of delays may have been documented in separate but related case files that were not selected for our review during this inspection.[24]

STANDARD 6	A Unit's case mix, as practicable, covers all significant provider types and includes a balance of fraud and, where appropriate, patient abuse and neglect cases.

Observation

The Unit's caseload included both fraud cases and patient abuse or neglect cases, covering a broad mix of provider types. Of the 464 nonglobal cases that were open during the review period, 60 percent (280 cases) involved provider fraud and 40 percent (184 cases) involved patient abuse or neglect. During the review period, the Unit's cases

[24] We confirmed that in at least one instance, documentation explaining the cause of an investigative delay was noted in another separate but related case file. However, we did not formally review all related case files that were not selected as part of our case file review sample.

covered 50 provider types, including medical doctors, home health care providers, and pharmaceutical manufacturers.

STANDARD 7	A Unit maintains case files in an effective manner and develops a case management system that allows efficient access to case information and other performance data.

Findings

The Unit's case management system posed challenges for retrieving case information and performance data. Performance Standard 7(f) states that a Unit should have a system that allows for the monitoring and reporting of case information. At the time of our inspection, the Unit used the South Carolina Office of the Attorney General's (OAG's) case management system and document repository to track key case information electronically. One supervising official stated that all divisions within the OAG were required to use the same case management system. Although OAG officials began a project in 2018 to adopt a new case management system, a new system had not been adopted at the time of our inspection.

Unit management and staff stated, and we found, that the Unit's current case management system does not allow the Unit to monitor case progression. To mitigate the shortcomings of the case management system, the Unit used standard forms and spreadsheets to document case information and progression. During the course of our inspection, we provided the Unit with technical assistance regarding additional methods by which the Unit may attempt to mitigate case management system inefficiencies, including possible ways to document and track related cases and cases worked jointly with other agencies.

Additionally, we found that the Unit did not store and maintain its case information in a manner that allowed the Unit to efficiently generate performance data reports. Rather than using the case management system to generate and report case information, the Unit maintained a separate "Master Case List" spreadsheet to track performance data required for State and Federal reporting purposes.

The Unit did not consistently document periodic supervisory reviews in its case files. According to Performance Standard 7(a), reviews by supervisors should be conducted periodically, consistent with the Unit's policies and procedures, and should be noted in the case file. During OIG's 2011 onsite review of the Unit, we found inconsistencies in the Unit's periodic supervisory reviews. Specifically, we found in that review that 61 percent of the Unit's case files were missing documentation of periodic supervisory reviews. We recommended that the Unit ensure that periodic supervisory reviews are documented in the Unit's case files. In

response to the recommendation, in 2013 the Unit developed a case status form to document periodic supervisory reviews. During our recent inspection, OIG observed that while the Unit relied on the case status form to document periodic supervisory reviews, the documentation of those reviews remained inconsistent.

The Unit's policy manual stated that quarterly file reviews would be held in January, April, July, and October. However, Unit management explained that due to regular engagement and interaction within the Unit, cases were generally discussed in team meetings or other informal conversations on a regular basis, but that these informal discussions were not consistently documented in the Unit's case files. The Unit director stated that during the review period, Unit management had intermittently attempted to hold at least quarterly supervisory case file review meetings and that the Unit intended to institute formal quarterly case reviews in the future.

We reviewed sampled case files to determine whether they contained documentation of supervisory reviews in January, April, July, and October, consistent with the Unit's written policy. We found that 83 percent of case files lacked documentation of one or more periodic supervisory reviews consistent with this policy.

Because the Unit director informed us that the Unit had attempted to hold quarterly reviews at various times within the review period, we also reviewed sampled case files open longer than 90 days to determine whether they contained consistent documentation of quarterly supervisory reviews. We found that 82 percent of case files open longer than 90 days lacked documentation of one or more periodic supervisory reviews. Some case files contained no documentation of supervisory reviews or contained gaps of more than 3 months to over 2 years with no supervisory reviews documented in the file.

Periodic supervisory reviews provide supervisors and investigators the opportunity to discuss the status of and next steps for Unit investigations. The reviews also serve as tools for supervisors to hold investigators accountable for their case file documentation as investigations progress. The lack of consistent documentation of these reviews may make it difficult for managers to ensure that these discussions are occurring regularly and that cases are completed timely. Additionally, ensuring that case files are reviewed at regular intervals can help Unit managers and staff ensure that cases progress timely even if there is turnover in the staff assigned to investigations.

STANDARD 8	A Unit cooperates with OIG and other Federal agencies in the investigation and prosecution of Medicaid and other health care fraud.

Observation

The Unit cooperated with OIG and the U.S. Attorney's Office in the investigation and prosecution of fraud cases. During the review period, the Unit maintained an excellent working relationship with OIG and jointly investigated a total of 21 cases. One OIG investigative manager described the Unit as "a great law enforcement partner with a cadre of smart, knowledgeable, and dependable staff."

We identified a strong relationship and high level of collaboration between the MFCU and the U.S. Attorney's Office in South Carolina. We observed that the Unit maintained a strong relationship with both the criminal and civil divisions of the U.S. Attorney's Office. One Assistant U.S. Attorney attributed the successful relationship to the established work history between the U.S. Attorney's Office and the MFCU and stated that the MFCU did "an excellent job" investigating and prosecuting cases and was "a well-respected group in the South Carolina criminal law community." The Unit's strong relationship with the U.S. Attorney's Office may have also been partially attributable to the fact that the former MFCU Director now serves as an Assistant U.S. Attorney in the office's Civil Division.[25]

Finding

The Unit did not consistently report convictions or adverse actions to Federal partners within the appropriate timeframes consistent with regulatory requirements. According to Federal requirements and Performance Standard 8(f), Units should transmit to OIG—within 30 days of sentencing—reports of all convictions so that convicted individuals can be excluded from Federal health care programs.[26] The Unit did not report 10 (24 percent) of its 41 convictions to OIG within the appropriate timeframe. Specifically, the Unit reported 8 convictions within 31 to 60 days after sentencing and 2 convictions more than 90 days after sentencing. The Unit attributed three of the late submissions to delays in receiving the necessary information from the court.

Federal regulations also require that Units report any adverse actions resulting from investigations or prosecution of health care providers to

[25] At the time of our inspection, the previous MFCU Director, who had served as Director from 2016 to 2019, served as an Assistant U.S. Attorney in the Office's Civil Division. During her tenure as MFCU Director, she was cross-designated as a Special Assistant U.S. Attorney and jointly prosecuted cases with the U.S. Attorney's Office.

[26] Effective May 21, 2019, 42 CFR 1007.11(g) required the Unit to transmit information on convictions within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court.

the NPDB within 30 calendar days of the date of the final adverse action.[27] Performance Standard 8(g) also states that the Unit should report qualifying cases to the NPDB.[28] The Unit did not report 15 (37 percent) of its 41 adverse actions to the NPDB within the appropriate timeframe. Of the 15 adverse actions submitted late, 12 were submitted within 31 to 60 days after the action, 1 was submitted within 61 to 90 days after the action, and 2 were submitted more than 90 days after the action.

Unit management attributed the delayed submissions to internal processing delays such as State holidays and employee leave, delays in obtaining necessary court documents timely, and delays resulting from the COVID-19 pandemic.

STANDARD 9	A Unit makes statutory or programmatic recommendations, when warranted, to the State government.

Observation

The Unit made program recommendations to the State Medicaid agency. The Unit identified potential program deficiencies and made program recommendations to the State Medicaid agency. For example, during the review period, the Unit recommended that the State Medicaid agency (1) coordinate with the South Carolina Labor Licensing and Regulations investigators to address cases of potential Medicaid fraud; and (2) revoke the enrollment of providers who submit false information on their provider enrollment applications. We confirmed that the State Medicaid agency had implemented these recommendations.

STANDARD 10	A Unit periodically reviews its Memorandum of Understanding (MOU) with the State Medicaid agency to ensure that it reflects current practice, policy, and legal requirements.

Finding

The Unit's MOU with the State Medicaid agency generally reflected current practice, policy, and legal requirements with the exception of a regulatory requirement regarding procedures for the receipt of managed care referrals. The MFCU and the SCDHHS had an MOU executed in August 2020.[29] The MOU generally reflected current practice, policy, and legal requirements, with the exception of the

[27] 45 CFR 60.5. Examples of adverse actions include but are not limited to convictions, civil judgments (but not civil settlements), and program exclusions. See SSA § 1128E(a) and (g)(1).

[28] The NPDB is intended to restrict the ability of physicians, dentists, and other health care practitioners to move from State to State without disclosure or discovery of previous medical malpractice and adverse actions. If a Unit fails to report adverse actions to the NPDB, individuals may be able to find new health care employment with an organization that is not aware of the adverse action made against them.

[29] During most of our review period, the MFCU and SCDHHS operated under an MOU executed in April 2013.

regulatory requirement that the Unit and the State Medicaid agency establish procedures by which the Unit will receive referrals of potential fraud from MCOs, if applicable. The Unit provided OIG with a document that included procedures for receiving MCO referrals; however, the process was not incorporated by reference or otherwise included in the MOU.

During our 2011 inspection of the Unit, we found that the Unit had not updated its MOU with the State Medicaid agency to reflect current law and practices in place at the time of our inspection. We recommended that the Unit revise the MOU to reflect the current practices and legal requirements. The Unit and the State Medicaid agency amended the MOU in 2013 to adhere to requirements in place at that time. The Unit and the State Medicaid agency again amended the MOU in 2020.

MFCU regulations effective on May 21, 2019, require the Unit and the Medicaid agency to agree to establish procedures by which the Unit will receive referrals of potential fraud from MCOs either directly or through the Medicaid agency.[30] We found that the MOUs in place during our inspection period did not include such procedures, either expressly or by reference. Further, despite the existence of written procedures regarding the receipt of MCO referrals, there did not appear to be a consistent understanding as to whether referrals to the Unit were to be sent directly from the MCOs or indirectly through the State Medicaid agency.

STANDARD 11	A Unit exercises proper fiscal control over its resources.

Observation

From OIG's limited review, we identified no deficiencies in the Unit's fiscal control of its resources. From the Unit's responses to a detailed fiscal controls questionnaire and follow-up with fiscal staff, we identified no internal control issues related to the Unit's budget process, accounting system, cash management, procurement, electronic data security, property, or personnel.

STANDARD 12	A Unit conducts training that aids in the mission of the Unit.

Observation

The Unit maintained a training plan for each professional discipline. The Unit had an annual training plan that required Unit attorneys, investigators, and auditors to complete an annual minimum number of

[30] 42 CFR § 1007.9(d)(3)(iv).

training hours. The plan required Unit employees to complete in-house basic training, as well as Medicaid fraud and discipline-specific training.

CONCLUSION AND RECOMMENDATIONS

From the information reviewed, we found that the South Carolina MFCU successfully investigated and prosecuted cases of Medicaid fraud and patient abuse or neglect when compared to MFCUs with similar staff sizes. We also observed that the Unit's State and Federal partners reported positive, cooperative relationships and held the South Carolina MFCU in high respect. For FYs 2018–2020, we identified six areas in which the Unit should improve its adherence to program standards and/or requirements. We found that low staff levels and significant turnover contributed to large caseloads for Unit staff. We also found that in 16 percent of the Unit's case files, the Unit did not document the reason for significant investigative delays. Further, the Unit's case management system posed challenges for retrieving case information, and the Unit did not consistently document periodic supervisory reviews in its case files. Additionally, we found that the Unit did not consistently report convictions or adverse actions to Federal partners within the appropriate timeframes consistent with regulatory requirements. We also found that the Unit's MOU with the State Medicaid agency generally reflected current practice, policy, and legal requirements with the exception of a regulatory requirement regarding procedures for the receipt of managed care referrals.

We also made observations regarding Unit operations and practices, including a beneficial practice employed by the Unit that may serve as a model for other Units: Unit management notified referral sources of the Unit's decision to open formal investigations of incoming referrals.

To address the six findings identified in this report, we recommend that the South Carolina Unit:

Assess the adequacy of existing staffing levels, and if appropriate, consider a plan to expand the size of the Unit

The Unit should assess whether staffing levels are sufficient for investigating cases of criminal and civil fraud and patient abuse and neglect in a timely manner and commensurate with the State's total Medicaid program expenditures. The Unit should share its findings with OIG, and on the basis of its assessment, the Unit should, if appropriate, consider an expansion plan to increase the number of staff to meet the needs of the Medicaid program. The Unit could also share the plan with the State legislature as the legislature considers proposed legislation to reform the State's current compensation system. The Unit's expansion plan could include plans for (1) seeking approval for additional staff to enable the Unit to effectively investigate and prosecute an appropriate volume of case referrals and workload; (2) improving

employee retention and reducing turnover (e.g., a review of current salaries and determination of what adjustments will need to be made to compete in the current market); and (3) revising the Unit's caseload management practices to lower staff caseloads, either by using different case management or prioritization techniques or through hiring additional staff.

Take steps to reduce investigation delays and ensure that the reasons for delays are documented in the case files

Except for unavoidable delays imposed by resource constraints or other exigencies, the Unit should avoid extended delays to investigations. To reduce investigation delays, the Unit should review its caseload management practices, and if necessary, develop a plan to lower staff caseloads by using different case management or prioritization techniques and/or hiring additional staff. Further, as recommended below, the Unit should conduct periodic supervisory case file reviews, which will help ensure that cases do not have unnecessary investigative delays. Additionally, to demonstrate that extended delays were imposed by resource constraints or other exigencies, the Unit should document such occurrences in the case files.

Seek approval from the South Carolina Office of the Attorney General to implement a new case management system

The Unit should seek approval from OAG officials to implement a new system that allows for efficient access to case information and performance data. While awaiting approval for a new case management system, the Unit should continue to take steps to mitigate the shortcomings of the current case management system and to improve access to case information and performance data.

Take steps to ensure that supervisory reviews of Unit case files are conducted periodically and documented in accordance with Unit policy

The Unit should take steps to ensure that supervisory reviews of Unit case files are conducted periodically, consistent with Unit policy, and documented in the Unit's case files. The Unit should include in its policies and procedures manual a specific frequency for conducting periodic supervisory reviews of Unit case files and take steps to ensure that supervisors and staff adhere to the policy. For example, the Unit could consider implementing automatic reminders to ensure that reviews are conducted according to Unit policy. The Unit should also include in its policies and procedures manual processes for ensuring that periodic supervisory case file reviews are documented in the Unit's case files and take steps to ensure that supervisors and staff adhere to the Unit policy.

Take steps to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes

The Unit should take steps to ensure that it consistently reports all convictions obtained in any case investigated by the Unit to OIG within 30 days of sentencing, or as soon as practicable if the Unit encounters delays in receiving the necessary information from the court, and adverse actions to the NPDB within 30 days of the action. The Unit should inform staff that all convictions must be reported to Federal partners timely. Additionally, the Unit could implement automated reminders that alert Unit staff about when to report convictions and adverse actions to Federal partners.

Revise the Unit's MOU with the State Medicaid agency to establish procedures by which the Unit will receive referrals of potential fraud from managed care organizations

To ensure compliance with Federal regulations found at 42 CFR § 1007.9(d)(3)(iv), the Unit should revise its MOU with SCDHHS to include procedures, either as part of the MOU or by reference to another document, by which the Unit will receive referrals of potential fraud originating from MCOs.

UNIT COMMENTS AND OIG RESPONSE

The Unit concurred with all six recommendations.

The Unit concurred with our first recommendation to assess the adequacy of existing staffing levels, and if appropriate, consider a plan to expand the size of the Unit. The Unit stated that it assessed its current staffing level and caseloads and determined that it would be appropriate to expand the size of the Unit. The Unit stated that it will seek to add two investigators and one auditor in FY 2022. The Unit also stated that it will assess the Unit's performance during FY 2022 to determine if more staff should be added in FY 2023.

The Unit also concurred with our second recommendation to take steps to reduce investigation delays and ensure that the reasons for delays are documented in the case files. The Unit stated that it is implementing measures to reduce investigative delays. For example, the Unit stated that it is taking steps to increase investigative staff, thereby reducing investigators' caseloads, and that the Unit's newly appointed Assistant Chief Investigator is assisting with the vetting of referrals to reduce the overall number of cases opened. The Unit also stated that it is taking steps to improve documentation of delays by improving the ease of access to its electronic case status forms used to record all case activity.

The Unit concurred with our third recommendation to seek approval from the OAG to implement a new case management system. The Unit stated that it notified the OAG's management of its case tracking and reporting needs and that the OAG is evaluating new case management options.

The Unit concurred with our fourth recommendation to take steps to ensure that supervisory reviews of Unit case files are conducted periodically and documented in accordance with Unit policy. The Unit stated that it revised its policy to require quarterly supervisory reviews of Unit case files and trained staff regarding the requirements of those reviews and how they should be recorded. Additionally, the Unit stated that it created Deputy Director and Assistant Chief Investigator positions to assist with this responsibility. Finally, the Unit stated that it revised its case status form to include a field for recording dates of supervisory reviews.

The Unit also concurred with our fifth recommendation to take steps to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes. The Unit stated that the Unit's attorneys will be primarily responsible for ensuring that convictions and adverse actions are reported within appropriate timeframes.

Finally, the Unit concurred with our sixth recommendation, that the Unit revise its MOU with the State Medicaid agency to establish procedures by which the Unit will

receive referrals of potential fraud from MCOs. The Unit stated that it intends to revise its MOU accordingly.

For the full text of the Unit's comments, see Appendix C.

DETAILED METHODOLOGY

Data Collection and Analysis

We collected and analyzed data from the six sources below to identify any opportunities for improvement and instances in which the Unit did not adhere to the MFCU performance standards or was not operating in accordance with laws, regulations, or policy transmittals. We also used the data sources to make observations about the Unit's case outcomes as well as the Unit's operations and practices concerning the performance standards. Because we conducted the inspection remotely due to the COVID-19 pandemic, we were unable to observe the Unit's physical workspace in person.

Review of Unit Documentation

Prior to the inspection, we reviewed the recertification analysis for FYs 2018–2020, which involved examining the Unit's recertification materials, including (1) the annual reports; (2) the Unit director's recertification questionnaires; (3) the Unit's MOU with the State Medicaid agency, SCDHHS; (4) the SCDHHS program integrity director's questionnaires; and (5) the OIG Special Agent in Charge questionnaires. We also reviewed the Unit's policies and procedures manual and the Unit's self-reported case outcomes and referrals included in its annual statistical reports for FYs 2018–2020. Additionally, we examined the recommendations from the 2011 OIG onsite review report and the Unit's implementation of those recommendations.

Review of Unit Financial Documentation

We conducted a limited review of the Unit's control over its fiscal resources. Prior to the inspection, we analyzed the Unit's response to a questionnaire about internal controls and conducted a review of the Unit's financial status reports. We followed up with officials in the South Carolina Office of the Attorney General and the Unit to clarify any issues identified in the questionnaire about internal controls.

Interviews with Key Stakeholders

In October 2020, we interviewed key stakeholders, including officials in SCDHHS, the U.S. Attorney's Office, the State Long-Term Care Ombudsman's Office, and the South Carolina Department of Health and Environmental Control. We also interviewed two special agents from OIG's Office of Investigations who work with the Unit. We focused these interviews on the Unit's relationship and interaction with the stakeholders, as well as opportunities for improvement. We used the information collected from these interviews to develop subsequent interview questions for Unit management and staff.

Interviews with Unit Management and Selected Staff

We conducted structured interviews with the Unit's management and selected staff in January 2021. We also conducted a structured interview with the Unit's chief investigator in October 2020 before she departed the Unit. Additional Unit management that we interviewed included the director, the deputy director, and the new chief investigator. Of the selected staff, we interviewed one attorney, two investigators, one auditor, and one nurse investigator. In addition, we interviewed the supervisor of the Unit—the Senior Assistant Deputy Attorney General. We asked these individuals questions related to (1) Unit operations; (2) Unit practices that contributed to the effectiveness and efficiency of Unit operations and/or performance; (3) opportunities for the Unit to improve its operations and/or performance; (4) clarification regarding information obtained from other data sources; and (5) the Unit's training and technical assistance needs.

Review of Case Files

To craft a sampling frame, we requested that the Unit provide us with a list of cases that were open at any time during FYs 2018–2020 and include the status of the case; whether the case was criminal, civil, or global; and the dates on which the case was opened and closed, if applicable. The total number of cases was 556.

We excluded all global cases from our review of the Unit's case files because global cases are civil false claims actions that typically involve multiple agencies, such as the U.S. Department of Justice and a group of State MFCUs. We excluded 92 global cases, leaving 464 case files.

We then selected a simple random sample of 88 cases from the population of 464 cases. This sample allowed us to make estimates of the overall percentage of case files with various characteristics with an absolute precision of +/- 10 percent at the 95-percent confidence level. We reviewed the 88 case files for adherence to the relevant performance standards and compliance with statute, regulation, and policy transmittals. During the review of the sampled case files, we consulted MFCU staff to address any apparent issues with individual case files, such as missing documentation.

Review of Unit Submissions to the Office of Inspector General and the National Practitioner Data Bank

We also reviewed all 41 convictions submitted to OIG for program exclusion during our review period, and all 41 adverse actions submitted to the NPDB during our review period. We reviewed whether the Unit submitted information on all sentenced individuals and entities to OIG for program exclusion and all adverse actions to the NPDB for FYs 2018–2020. We also assessed the timeliness of the submissions to OIG and the NPDB.

APPENDIX A

Unit Referrals by Source for Fiscal Years 2018 Through 2020

	FY 2018		FY 2019		FY 2020		Grand Totals	
Referral Source	**Fraud**	**Abuse or Neglect**	**Fraud**	**Abuse or Neglect**	**Fraud**	**Abuse or Neglect**	**Fraud**	**Abuse or Neglect**
Adult Protective Services	0	2	0	0	0	1	0	3
Anonymous	0	0	4	2	2	0	6	2
HHS—Office of Inspector General (OIG)	3	0	6	1	3	0	12	1
Law Enforcement Other	10	7	4	14	1	14	15	35
Local Prosecutor	0	5	0	0	0	0	0	5
Long-Term Care Ombudsman	1	4	0	8	0	8	1	20
Managed Care Organizations	7	0	22	0	15	0	44	0
Medicaid Agency Other	0	0	0	0	1	0	1	0
Medicaid Agency PI/SURS[1]	6	0	4	0	10	1	20	1
Private Citizen	22	14	9	2	14	8	45	24
Private Health Insurer	0	0	1	0	0	0	1	0
Provider	5	15	4	11	18	24	27	50
State Agency Other	5	3	8	6	10	6	23	15
Other	17	0	31	6	63	10	111	16
Total	**76**	**50**	**93**	**50**	**137**	**72**	**306**	**172**
Annual Total	**126**		**143**		**209**		**478**	

Source: OIG analysis of Unit Annual Statistical Reports, FYs 2018–20.

[1] The abbreviation "PI" stands for program integrity; the abbreviation "SURS" stands for "Surveillance and Utilization Reviews."

APPENDIX B

Point Estimates and 95-Percent Confidence Intervals of Case File Reviews

Estimate Description	Sample Size	Point Estimate	95-Percent Confidence Interval	
			Lower	Upper
Percentage of All Cases with Significant Investigative Delays	88	37.5%	28.2%	47.6%
Percentage of All Cases with Significant Investigative Delays That Were Unexplained	88	15.9%	9.5%	24.4%
Percentage of All Cases Closed at the Time of OIG's Review	88	51.1%	41.2%	61.0%
Percentage of All Cases That Had Supervisory Approval To Open	88	100.0%	96.1%	100.0%
Percentage of All Closed Cases That Had Supervisory Approval To Close	45	100.0%	92.8%	100.0%
Percentage of All Cases That Did Not Contain Documentation of Supervisory Review in January, April, July, and October According to Unit Policy	88	83.0%	74.4%	89.7%
Percentage of All Cases Open Longer Than 90 Days	88	96.6%	90.9%	99.1%
Percentage of All Case Files Open Longer Than 90 Days and That Contained No Documentation of Periodic Supervisory Review	85	15.3%	8.9%	23.9%
Percentage of All Case Files Open Longer Than 90 Days and That Contained Some Periodic Supervisory Review, but Not Quarterly Supervisory Review	85	82.4%	73.4%	89.3%

Source: OIG analysis of South Carolina MFCU case files, 2021.

APPENDIX C

Unit Comments

August 31, 2021

VIA ELECTRONIC MAIL

Ms. Suzanne Murrin
Deputy Inspector General
Office of Inspector General
Department of Health and Human Services
Room 5660 Cohen Building
330 Independence Ave, SW
Washington, DC 20201

RE: South Carolina MFCU 2020 Onsite Review

Dear Ms. Murrin:

The State of South Carolina is in receipt of HHS-OIG's draft report entitled *South Carolina Medicaid Fraud Control Unit: 2020 Inspection,* OEI-12-20-00610. The Unit would like to express its appreciation to OIG for its feedback contained in this draft report, as well as its cooperation and assistance as we navigated an unprecedented remote audit due to the COVID-19 pandemic.

As requested, this letter contains the Unit's response to the recommendations contained in the report.

RECOMMENDATION ONE: Assess the adequacy of existing staffing levels and, if appropriate, consider a plan to expand the size of the Unit.

RESPONSE: The Unit concurs with this recommendation.

The SCMFCU has assessed its current staffing level and case loads and determined that it is appropriate to expand the Unit. In FFY2022 the Unit seeks to add 2 additional special investigators and 1 additional auditor. The Unit will reassess performance during FFY2022 to determine if additional increases are appropriate for FFY2023.

RECOMMENDATION TWO: Take steps to reduce investigation delays and ensure that the reasons for delays are documented in the case files.

RESPONSE: The Unit concurs with this recommendation.

The Unit is implementing measures both to (i) reduce investigative delays and (ii) improve documentation of delays.

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First, as noted above, the Unit is taking steps to increase its investigative staff, thereby, reducing case assignments per investigator. Additionally, the Unit's newly appointed Assistant Chief Investigator is assisting with vetting referrals prior to the Unit's opening a case, thus reducing the overall number of open cases.

Second, the Unit has obtained assistance from SCAG's IT Department to improve ease of access to its electronic case status forms, used to record all case activity. This should promote more routine and timely updates.

RECOMMENDATION THREE: Seek approval from the South Carolina Office of the Attorney General to implement a new case management system.

RESPONSE: The Unit concurs with this recommendation.

The Unit has notified SCAG management of its case tracking needs, specifically as related to HHS-OIG reporting requirements. SCAG is currently evaluating new case management options.

RECOMMENDATION FOUR: Take steps to ensure that supervisory reviews of Unit case files are conducted periodically and documented in accordance with Unit policy.

RESPONSE: The Unit concurs with this recommendation.

The Unit has already resolved this matter. As detailed below, in early 2021, the Unit implemented measures to: (i) update its policy regarding supervisory reviews, (ii) restructure so that supervisors have adequate time to conduct case reviews, and (iii) revised its operations to highlight this responsibility.

First, the Unit's revised policy requires supervisory reviews be conducted at least once quarterly. Staff have been trained on what constitutes a supervisory review and how such reviews are to be recorded.

Second, the Unit has created Deputy Director and Assistant Chief Investigator positions to distribute this responsibility.

Third, the Unit has revised its case status form to include a field for recording dates of supervisory reviews. This will provide a reminder that employees are obligated to participate in regular supervisory review meetings, as well as provide a method for verifying such reviews are occurring timely.

RECOMMENDATION FIVE: Take steps to ensure that all convictions and adverse actions are reported to Federal partners within the appropriate timeframes.

RESPONSE: The Unit concurs with this recommendation.

Rather than the Director and an Administrative Assistant being responsible for ensuring this task is completed timely, the Unit's attorney staff will now be primarily responsible for ensuring such reports are drafted and submitted. Attorney staff are most familiar with case facts and the scheduling of sentencing hearings. This metric has also been added to the Unit's Master Case List.

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RECOMMENDATION SIX: Revise the Unit's MOU with the State Medicaid agency to establish procedures by which the Unit will receive referrals of potential fraud from managed care organizations.

RESPONSE: The Unit concurs with this recommendation.

The Unit concurs with OIG's recommendation that its MOU with the State Medicaid agency be updated to reflect that the parties established procedures for receiving referrals from managed care organizations.

Thank you for allowing the Unit an opportunity to respond to the 2020 audit review findings. We look forward to working with you to continue improving the Unit's performance by implementing the above recommendations. If I may be of any additional assistance, please do not hesitate to contact me.

With kind regards, I am,

Very truly yours,

Stephanie Goddard
Assistant Deputy Attorney General
Director, Medicaid Fraud Control Unit

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ACKNOWLEDGMENTS AND CONTACT

Acknowledgments

Jordan Clementi of the Medicaid Fraud Policy and Oversight Division served as the team leader for this inspection. Keith Peters of the Medicaid Fraud Policy and Oversight Division also participated in the inspection. Office of Evaluation and Inspections staff who provided support include Kevin Farber, Christine Moritz, and Sarah Swisher.

Two agents from the Office of Investigations also participated in the inspection and provided technical assistance to the Unit.

This report was prepared under the direction of Richard Stern, Director of the Medicaid Fraud Policy and Oversight Division.

Contact

To obtain additional information concerning this report, contact the Office of Public Affairs at Public.Affairs@oig.hhs.gov. OIG reports and other information can be found on the OIG website at oig.hhs.gov.

Office of Inspector General
U.S. Department of Health and Human Services
330 Independence Avenue, SW
Washington, DC 20201

ABOUT THE OFFICE OF INSPECTOR GENERAL

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