Department of Health and Human Services
Office of Inspector General
Office of Audit Services

September 2026 | A-04-24-07115

South Carolina Did Not Ensure That Selected Medicaid Managed Care Organizations Complied With Mental Health and Substance Use Disorder Parity Requirements Related to Prior Authorization

REPORT HIGHLIGHTS

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Why OIG Did This Audit

- Individuals seeking care for mental health and substance use disorder (MH/SUD) conditions often find that treatment operates in a separate, and often very disparate, system than treatment for medical and surgical (M/S) care, even under the same health insurance coverage.
- Federal statute and regulations prohibit coverage limitations that apply more restrictively to MH/SUD benefits than to M/S benefits; these are called parity requirements. A March 2024 OIG audit found that CMS did not ensure that eight selected States complied with Medicaid managed care MH/SUD parity requirements.
- This audit determined whether South Carolina ensured that three selected Medicaid managed care organizations (MCOs) of its five complied with parity requirements related to prior authorization for MH/SUD services provided to their Medicaid enrollees during calendar year 2023 (audit period).

What OIG Found

South Carolina did not ensure that the three selected MCOs in the State complied with parity requirements related to prior authorization for MH/SUD services provided to their Medicaid enrollees.

- The three selected MCOs were unable to provide accurate and complete data of MH/SUD and M/S services requiring prior authorization.
- South Carolina did not review and validate the selected MCOs' data supporting denied prior authorization requests.
- Two of the three selected MCOs continued to be noncompliant with MH/SUD parity requirements during our audit period—more than 6 years after the October 2017 compliance dateline.

What OIG Recommends

We recommended South Carolina implement policies and procedures for monitoring the MCOs' compliance with parity requirements related to prior authorization for MH/SUD services, including: providing clear, uniform guidance to the MCOs to maintain and provide accurate, complete, and consistent data supporting services requiring prior authorization; reviewing and validating MCOs' data; and addressing with the MCOs any issues of noncompliance or potential noncompliance with parity requirements. The full recommendation is in the report.

South Carolina agreed with our recommendation.

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INTRODUCTION

WHY WE DID THIS AUDIT

In 2024, 61.5 million adults in the United States experienced some form of mental illness and an estimated 48.4 million people aged 12 or older had a substance use disorder. Individuals seeking care for mental health and substance use disorder (MH/SUD) conditions often find that treatment operates in a separate, and often very disparate, system than treatment for medical and surgical (M/S) care, even under the same health insurance coverage. Federal regulations implementing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) were put in place to make it easier for people with MH/SUD conditions to access treatment and services by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than to M/S benefits (i.e., parity in how the two types of benefits are covered by health insurers, including Medicaid managed care).

A March 2024 Office of Inspector General (OIG) audit found that the Centers for Medicare & Medicaid Services (CMS) did not ensure that eight selected States complied with Medicaid managed care MH/SUD parity requirements.[1] OIG is conducting a series of audits to determine whether some of the States covered in our prior report and their Medicaid managed care organizations (MCOs) complied with parity requirements for MH/SUD benefits related to prior authorization.[2] Our March 2024 audit identified that prior authorization was the most frequent nonquantitative treatment limitation (NQTL) area of noncompliance.[3] We are conducting this series of audits as part of Congressionally requested OIG work that addresses enrollees' access to MH/SUD services. We selected South Carolina based on findings related to NQTLs from our 2024 audit.

OBJECTIVE

Our objective was to determine whether the South Carolina Department of Health and Human Services (State agency) ensured that its MCOs complied with parity requirements related to prior authorization for MH/SUD services provided to their Medicaid enrollees.

[1] OIG, *CMS Did Not Ensure That Selected States Complied With Medicaid Managed Care Mental Health and Substance Use Disorder Parity Requirements* (A-02-22-01016), issued Mar. 25, 2024.

[2] Prior authorization is a cost-control process in which advance approval from a health plan is required before a service is performed and subsequently paid.

[3] NQTLs are restrictions on services that are not expressed numerically but that otherwise limit the scope and duration of benefits, including limiting benefits based on medical necessity, medical management policies (e.g., prior authorization), and standards for provider participation in a network.

BACKGROUND

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

The MHPAEA was intended to promote equal access to treatment for people with MH/SUD conditions by prohibiting coverage limitations that apply more restrictively to MH/SUD benefits than they do to M/S benefits. Such limitations may include higher copayments, separate deductibles, and stricter preauthorization or medical necessity reviews, as compared to other covered medical treatments.

Mental Health and Substance Use Disorder Parity Requirements and CMS Guidance

CMS issued a final rule in March 2016 that addressed how the MH/SUD parity requirements of the MHPAEA apply to coverage offered by MCOs to Medicaid enrollees.[4] The regulations require States to ensure that all services delivered to MCO enrollees comply with parity requirements. States and their MCOs were required to comply with parity requirements by October 2, 2017 (the compliance date).[5] Specifically, States or their MCOs are required to conduct ongoing parity analyses to assess whether MH/SUD benefits are covered in a way that is no more restrictive than M/S benefits.[6] The parity analyses compare limitations on benefits for MH/SUD services with those for M/S services in four benefit classifications: inpatient, outpatient, prescription drugs, and emergency care.[7]

NQTLs are restrictions on services that are not expressed numerically but that otherwise limit the scope or duration of benefits. NQTLs include, but are not limited to, medical necessity criteria, medical management protocols (e.g., prior authorization and concurrent review), and reimbursement rates. The regulations require that an MCO not impose limitations, including prior authorization for MH/SUD benefits, unless the limitations applied to MH/SUD benefits in any classification—under the policies and procedures of the MCO "as written" or "in operation"—are comparable to, and applied no more stringently than, the limitations applied to M/S benefits in the same benefit classification. For this report, we define "as written" to refer to an MCO's policies and procedures. We also define "in operation" to refer to the processes through which an MCO applies those policies and procedures in practice.

[4] 81 Fed. Reg. 18390 (Mar. 30, 2016).

[5] Section 1932(b)(8) of the Social Security Act and implementing regulations at 42 CFR § 438.930.

[6] 42 CFR § 438.920.

[7] 42 CFR §§ 438.905, 438.910, and 438.915. Parity does not mandate coverage of MH/SUD benefits. However, when coverage for MH/SUD services is provided, coverage must be provided in every classification in which M/S services are provided.

CMS has provided (in January 2017) guidance on the MH/SUD parity requirements of the MHPAEA to the State agencies in the form of a self-compliance toolkit.[8] The toolkit provides a basic understanding of the MHPAEA to assist States in assessing compliance with parity requirements. The toolkit explains that the MHPAEA prohibits the imposition of NQTLs, including prior authorization denials, on MH/SUD services in any benefit classification. Specifically, this toolkit explains that the MHPAEA regulations prohibit a plan from imposing NQTLs on MH/SUD benefits in any benefit classification unless, under the terms of the plan or coverage "as written and in operation," any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to M/S benefits in the same classification.

South Carolina Mental Health and Substance Use Disorder Parity Oversight

To comply with Federal requirements, South Carolina is required to conduct a parity analysis to ensure that MCOs comply with parity requirements because the full scope of MH/SUD services are not provided through the MCOs.[9] In addition, the State agency is required to have in effect a monitoring system that addresses all aspects of the managed care program.[10]

For calendar year (CY) 2023, the State agency contracted with five MCOs to coordinate health care (both MH/SUD and M/S services) for individuals in South Carolina who were enrolled in Medicaid.

To determine whether its MCOs complied with mental health parity requirements, the State agency used an external quality review organization to conduct mental health parity assessments as part of each contracted MCO's annual external quality review. For each MCO, the external quality review organization conducted this parity assessment as a two-step process.

- The first step involved assessing the quantitative treatment limitations, which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits.

- The second step assessed the NQTLs, such as medical management standards, provider network admission standards and reimbursement rates, and other limits on the scope or duration of benefits.

[8] CMS, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs," (accessed on Apr. 21, 2026).

[9] 42 CFR § 438.920(b).

[10] 42 CFR § 438.66.

The external quality review organization worked with each of the MCOs to collect information, including medical program descriptions, various utilization and network access reports, member and provider handbooks, and benefit maps. The parity assessments identified the relative strengths and weaknesses of the plans and included recommendations for corrective actions for any identified weaknesses.

In addition, as part of the State agency's monitoring activities related to prior authorization, the State agency collects, from each MCO, quarterly service authorization reports that list all approved and denied services requiring prior authorization.[11] The reports categorized the services requested by type of service: inpatient, outpatient, pharmacy benefits, inpatient behavioral health, or outpatient behavioral health.[12]

HOW WE CONDUCTED THIS AUDIT

We selected a nonstatistical sample of three of the five MCOs in South Carolina with contracts to provide access to MH/SUD services. The selected MCOs covered approximately 80 percent of South Carolina's Medicaid managed care enrollees. Our audit period included MH/SUD services provided to Medicaid enrollees during CY 2023, which was part of the most recent 3-year MCO contract period in effect at the beginning of our audit.[13] We selected the MCOs based on an analysis of risk factors that included: (1) prior authorization NQTL noncompliance identified in multiple benefit classifications (e.g., inpatient, outpatient, and prescription drugs), (2) number of enrollees served by the MCO, and (3) the MCOs' use of subcontractors for claims adjudication and denials of service.[14] We reviewed the State agency's oversight of its MCOs' compliance with parity requirements for MH/SUD services related to prior authorization of those services compared to M/S services in the same benefit classifications.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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[11] "Prior authorization" describes the process by which a provider obtains approval from the MCO for services to be rendered. The term "service authorization" refers more broadly to both prior authorization for care and continuation of care. For this audit report, we use "service authorization" when referring to reports and data that MCOs furnish to the State agency and, upon request, to CMS.

[12] The types of services listed here do not correspond directly with the four benefit classifications mentioned earlier in this report.

[13] The 3-year contract period for the three selected MCOs ran from July 1, 2021, through June 30, 2024.

[14] A State agency's focus surveys cited that specific MH/SUD services were denied at a higher rate when a subcontractor adjudicated or denied claims. One of our three selected MCOs used a subcontractor to adjudicate and deny claims for MH/SUD services.

Appendix A contains the details of our audit scope and methodology.

FINDINGS

Although we determined that all selected MCOs' practices "as written" for the rendering of MH/SUD services complied with parity requirements related to prior authorization, overall, the State agency did not ensure that the three selected MCOs complied with parity requirements related to prior authorization for MH/SUD services provided to their Medicaid enrollees. Specifically, we found that: (1) the three selected MCOs were unable to provide accurate and complete data of MH/SUD and M/S services requiring prior authorization; (2) the State agency did not review and validate the selected MCOs' data supporting denied prior authorization requests; and (3) two of the three selected MCOs continued to be noncompliant with MH/SUD parity requirements during our audit period—more than 6 years after the compliance date.

These deficiencies occurred because of inadequacies in the State agency's monitoring activities. The State agency did not have policies and procedures that required the MCOs to maintain uniform, complete, and accurate data that the State agency could use to complete the required parity analyses. In addition, the State agency did not have policies and procedures that would enable it to effectively monitor MCOs' compliance with parity requirements. Furthermore, the State agency did not review the parity assessments that its contracted external quality review organization conducted. As a result of these inadequacies in its monitoring activities, the State agency could not determine whether the MCOs delivered services that required prior authorization in accordance with parity requirements and could not develop a corrective action plan to address these issues. Accordingly, these circumstances may have increased the risk that Medicaid enrollees would encounter delays or barriers to needed MH/SUD treatments.

SELECTED MANAGED CARE ORGANIZATIONS' SERVICE AUTHORIZATIONS DATA WERE NOT ACCURATE AND COMPLETE

To comply with Federal requirements, the State agency is required to conduct a parity analysis to ensure that MCOs comply with parity requirements because the full scope of MH/SUD services are not provided through the MCOs.[15] In South Carolina, the State agency requires the MCOs to comply with mental health parity requirements.[16] MCOs are also required to maintain health information systems that collect, analyze, integrate, and report data. Health information systems must maintain information on Medicaid coverage including, but not limited to, utilization, claims, and appeals.[17]

Federal regulations direct the State agency to require MCOs to ensure that data collected from providers are accurate and complete by: (1) verifying the accuracy and timeliness of reported

[15] 42 CFR § 438.920(b).

[16] South Carolina's MCO Model Contract § 4.2.5.2.

[17] 42 CFR § 438.242(a) and South Carolina's MCO Model Contract § 13.1.1.

data; (2) screening the data for completeness, logic, and consistency; and (3) collecting data from providers in standardized formats to the extent feasible and appropriate.[18] In addition, Federal regulations require MCOs to make all collected data available to the State agency and, upon request, to CMS.[19]

Accordingly, the State agency should ensure that MCOs collect and maintain accurate and complete data that could be used to complete parity analyses to determine whether MH/SUD services requiring prior authorization were provided in parity with M/S services in the same benefit classification (i.e., inpatient, outpatient, and prescription drugs). All three selected MCOs were unable to provide OIG with accurate and complete data of MH/SUD and M/S services requiring prior authorization during our audit period. As examples, the data that OIG collected from MCOs showed that:

- One MCO incorrectly identified 169 of 822 requests for prior authorizations as denied when these requests should have been listed as approved. The service authorizations data in this MCO's health information system indicated that the requests had been denied; however, the payment status indicator in the same system showed these requests as either paid or paid on appeal. The MCO had initially denied these requests but subsequently approved them after further internal review or after appeal (by either the enrollees or the service providers) and paid the corresponding claims that the providers had submitted. However, the MCO's quarterly service authorization report did not reflect a revised approved status for these 169 requests.

- One MCO classified 616 of 103,128 requests for authorizations for outpatient services as M/S services, but these requests should have been classified as MH/SUD services. The primary diagnosis code that the MCO reported with these requests corresponded to a mental or behavioral disorder.

- One MCO did not identify the specific service that had been requested for all 18,647 prior authorization requests for pharmacy benefits that this MCO denied. Also, 4,639 of these denied requests for pharmacy benefits either did not indicate whether the services were related to an MH/SUD condition or an M/S condition or did not include the corresponding primary diagnosis code for the proper classification as an MH/SUD condition or an M/S condition. Because this MCO did not identify the specific requested service for all 18,647 denied prior authorization requests, and because 4,639 of those denied requests lacked essential identifying data, we concluded that the State agency would be unable to complete the parity analyses associated with all of these denied prior authorization requests for pharmacy benefits.

[18] 42 CFR § 438.242(b)(3).

[19] 42 CFR § 438.242(b)(4).

- Two MCOs did not classify service authorizations data as inpatient, outpatient, or prescription drugs. When we discussed this finding with State agency officials, they said that the State agency would be better able to complete its parity analyses if each of these two MCOs had developed and provided a crosswalk to map the services for which prior authorizations had been requested to their corresponding benefit classifications. Although no Federal or State regulations direct MCOs to develop and use a crosswalk, it does represent a best practice that would assist both the MCOs and the State agency in the completion of the required parity analyses. The third selected MCO did provide a crosswalk that classified services requiring prior authorization as inpatient, outpatient, or prescription drugs.

- All three MCOs provided service authorizations data that were not uniform and that did not contain the same information or data fields. If the State agency had requested the data for our audit period to complete and compare parity analyses between each MCO, then it may have had difficulty drawing conclusions because of the different information provided by each MCO. Because the data that the MCOs collected from providers were not in standardized formats as specified in Federal regulations at 42 CFR § 438.242(b)(3), we concluded that the three selected MCOs were unable to provide accurate and complete data that would enable the State agency to complete and compare parity analyses.

- All three MCOs combined information for both mental health and substance use disorder services requiring prior authorization into a single category labeled as "behavioral health services" and compared this information to the same data for M/S services. Because the MCOs combined this information into a single category, the State agency could not complete its parity analyses.

- All three MCOs' service authorizations data did not support the quarterly service authorization reports that the MCOs submitted because there were discrepancies with the datasets, such that the data could not be reconciled.

These deficiencies occurred because the State agency did not have policies and procedures that required the MCOs to maintain uniform, complete, and accurate data that the State agency could use to complete parity analyses to determine whether MH/SUD services requiring prior authorization were provided in parity with M/S services in the same benefit classification.

As a result of the inaccurate and incomplete service authorizations data received from the MCOs, the State agency could not effectively complete parity analyses to determine whether: (1) the MCOs delivered services that required prior authorization in accordance with parity requirements or (2) any of the MCOs denied prior authorization requests for MH/SUD services at a higher rate than they denied prior authorization requests for M/S services in the same

benefit classification.[20] In addition, the State agency could not compare denial rates for certain MH/SUD services across MCOs to identify any potential systemic issues, because the service authorizations data maintained by the MCOs were not uniform and conveyed different information from each MCO.

THE STATE AGENCY DID NOT REVIEW DATA SUPPORTING SELECTED MANAGED CARE ORGANIZATIONS' QUARTERLY SERVICE AUTHORIZATION REPORTS

States or their MCOs are required to conduct parity analyses to assess whether MH/SUD benefits are covered in a way that is no more restrictive than M/S benefits.[21] States must ensure that all services are delivered to MCO enrollees in compliance with parity requirements.[22] MCOs with Medicaid health insurance plans are also required to comply with MH/SUD parity requirements. MCOs may not impose NQTLs, such as prior authorization restrictions, for MH/SUD benefits in any benefit classification unless such limitations are comparable to and applied no more stringently than M/S benefits in the same classification.[23] Further, States are required to have in effect a monitoring system that addresses all aspects of the managed care program.[24]

For all three of the selected MCOs, the State agency did not review the MCOs' data supporting quarterly service authorization reports. In addition, during our audit period the State agency did not perform parity analyses of the reported services requiring prior authorization to calculate prior authorization denial rates for MH/SUD services and compare these rates to the calculated prior authorization denial rates for M/S services. As previously stated, this kind of comparison is not a requirement but represents a best practice that would help the State agency flag potential noncompliance with parity requirements (footnote 20). During our audit period, the State agency collected quarterly service authorization reports, which listed approved and denied services requiring prior authorization, from the MCOs.[25] We determined

[20] A higher rate of prior authorization denials for MH/SUD services as compared to the rate of denials for M/S services does not necessarily signify noncompliance with NQTL requirements. Rather, a higher rate could be an indicator of *potential* noncompliance with these requirements.

[21] 42 CFR § 438.920.

[22] 42 CFR § 438.920(b).

[23] 42 CFR § 438.910(d).

[24] 42 CFR § 438.66.

[25] The service authorization reports, submitted quarterly by the MCOs, listed all covered services provided by the MCOs that required prior authorization. These reports categorized the services requested by type of service (inpatient, outpatient, pharmacy benefits, inpatient behavioral health, or outpatient behavioral health) and included among other data fields, the enrollee's name and date of birth; the date service was requested, denied, or approved; and denial type.

that these service authorization reports provided only limited data that were not adequate to enable the State agency to perform the required parity analyses. Specifically:

- The quarterly service authorization reports that were obtained from the MCOs did not identify the specific service for which prior authorization had been requested. Rather, the reports indicated more broadly the type of service that was requested (i.e., inpatient, dental, pharmacy, skill nursing). In addition, the pharmacy benefits category did not specify whether the service was associated with an MH/SUD condition or an M/S condition.

- The reports that the MCOs submitted to the State agency combined information for both mental health and substance use disorder services requiring prior authorization into a single category labeled as "behavioral health services."

- The reports that the MCOs submitted to the State agency did not reconcile to the data in the quarterly service authorization reports that we obtained directly from the MCOs for CY 2023.

These deficiencies occurred because the State agency did not have policies and procedures that would enable it to effectively monitor MCOs' compliance with parity requirements. For example, the State agency did not have written policies and procedures to review and validate MCOs' data supporting denied prior authorization requests and to complete parity analyses of MH/SUD services and M/S services that require prior authorization. Furthermore, the State agency did not have a written policy that articulated the format and specific data fields for the quarterly service authorization reports for the MCOs to use to complete and report their parity analyses of MH/SUD services and M/S services that require prior authorization.

As a result, the State agency did not monitor whether the MCOs' prior authorization restrictions for MH/SUD benefits in any benefit classification were comparable to and applied no more stringently than M/S benefits in the same classification. The State agency's lack of oversight of MCOs' service authorization practices may not ensure that services delivered to MCOs' enrollees are in compliance with MH/SUD parity requirements.

SELECTED MEDICAID MANAGED CARE ORGANIZATIONS CONTINUED TO BE NONCOMPLIANT WITH PARITY REQUIREMENTS MORE THAN 6 YEARS AFTER THE COMPLIANCE DATE

All MCO contracts must provide for services to be delivered in compliance with MH/SUD parity requirements at 42 CFR part 438 subpart K, when applicable.[26] Contracts with MCOs offering Medicaid State plan services to enrollees at the time of the final rule had to comply with parity

[26] The relevant provisions regarding parity requirements from 42 CFR part 438 subpart K are 42 CFR §§ 438.900 through 438.930.

requirements by the compliance date (October 2017).[27] MCOs may be subject to sanctions and civil monetary penalties if they misrepresent information provided to the State agency, do not comply with contract terms, or violate any State or Federal laws governing MCOs.[28]

We found that two of the three selected MCOs continued to be noncompliant with MH/SUD parity requirements during our audit period—more than 6 years after the compliance date (October 2, 2017). Specifically:

- The mental health parity assessment conducted by the State agency's contractor[29] stated that one selected MCO was noncompliant with mental health parity requirements with respect to prior authorization denials because the MCO did not give the contractor the corresponding templates and reports required for the completion of the MH/SUD services parity assessment.

- The contractor did not complete the required mental health parity assessment for the second selected MCO until December 2024, which was after the end of our audit period. The contractor stated that at that point, this MCO was compliant with the mental health parity requirements with respect to prior authorization denials. However, the contractor also noted in its parity assessment that this MCO denied prior authorization requests for MH/SUD services at a higher rate than it denied prior authorization requests for M/S services in the same benefit classification (inpatient services). The contractor added that data on appeals were incomplete and noted that the processing of appeals can have a significant time lag.

Although the State agency's contractor determined that the third of our three selected MCOs was compliant with the mental health parity requirements with respect to prior authorization denials, the contractor noted in its parity assessment that like the second MCO, the third MCO denied prior authorization requests for MH/SUD services at a higher rate than it denied prior authorization requests for M/S services. The contractor recommended further examination of MCO's appeals data to determine the root cause of the discrepancy in denial rates (footnote 19).[30]

State agency officials told us that they were not aware of the issues of noncompliance or potential noncompliance that affected all three selected MCOs because the State agency did

[27] 42 CFR § 438.930.

[28] South Carolina's MCO Model Contract §18.3.

[29] The State agency uses the contracted external quality review organization (discussed in "South Carolina Mental Health and Substance Use Disorder Parity Oversight" earlier in this report) to conduct a mental health parity assessment, including reviewing quantitative treatment limitations and NQTLs, and identifying the relative strengths and weaknesses of the plans, as part of each MCO's annual external quality review.

[30] The contractor's parity assessment did not detail the specific rates of denial for the MH/SUD and M/S services and did not differentiate between the inpatient and outpatient benefit classification.

not review the parity assessments conducted by the contractor. Therefore, the State agency did not address these issues or develop a corrective action plan with the respective MCOs. The fact that the State agency did not take these steps pointed to possible vulnerabilities or weaknesses in its oversight of the MCOs' compliance with parity requirements for MH/SUD services related to prior authorization.

CONCLUSION

The State agency used an external quality review organization to conduct mental health parity assessments as part of each contracted MCO's annual external quality review to help ensure that the limits MCOs impose on MH/SUD services are comparable to and no more stringently applied than those for M/S services. However, we determined that the State agency did not adequately ensure that the three selected MCOs complied with parity requirements related to prior authorization for MH/SUD services during our audit period. We found that: (1) all three selected MCOs were unable to provide accurate and complete data of MH/SUD and M/S services requiring prior authorization; (2) the State agency did not review and validate the selected MCOs' data supporting denied prior authorization requests; and (3) two of the three selected MCOs continued to be noncompliant with MH/SUD parity requirements during our audit period—more than 6 years after the compliance date.

Because certain MCOs had not demonstrated compliance with parity requirements, access to MH/SUD services for their enrollees may have been limited compared to access for M/S services. Accordingly, this may have increased the risk that Medicaid enrollees would encounter delays or barriers to needed MH/SUD treatments. The State agency therefore has the opportunity to develop a parity compliance program and to implement policies and procedures for monitoring of MCOs' compliance with parity requirements related to prior authorization for MH/SUD services. In this context, the State agency's oversight of prior authorization denials, when rigorously executed, would help to ensure that MCOs are not inappropriately denying care to their Medicaid enrollees.

RECOMMENDATION

We recommend that the South Carolina Department of Health and Human Services implement policies and procedures for monitoring the MCOs' compliance with parity requirements, including: (1) providing clear, uniform guidance to the MCOs regarding maintaining and providing accurate, complete, and consistent data to support the MCOs' quarterly service authorization reports; (2) reviewing and validating the MCOs' data that support the MCOs' quarterly service authorization reports, so the State agency can accurately complete and report the parity analyses of MH/SUD services compared to M/S services that require prior authorization; and (3) addressing with the MCOs any issues of noncompliance or potential noncompliance with parity requirements and coordinating with the MCOs to develop corrective action plans.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our recommendation and described actions that it had taken to take to address it. For example, the State agency stated that it added additional fields and data elements to its templates for reporting service authorizations, added an additional report requiring MCOs to submit a listing of authorization requirements by benefit type, and added language to its MCO contract to appropriately document the responsibilities of reporting data elements to the State agency.

The State agency also stated that the additional reporting elements and improvements have allowed it to review and validate data submitted by its MCOs. Furthermore, the enhanced reporting and contractual language has given it the regulatory capability to fully address MH/SUD disparities related to its MCOs' authorization practices.

The State agency's comments appear in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We selected a nonstatistical sample of three of the five MCOs in South Carolina with contracts to provide access to MH/SUD services. These selected MCOs covered approximately 80 percent of South Carolina's Medicaid managed care enrollees. Our audit period included MH/SUD services provided to Medicaid enrollees during CY 2023, which was part of the most recent 3-year MCO contract period in effect at the beginning of our audit (footnote 13). We selected the MCOs based on an analysis of risk factors that included: (1) prior authorization NQTL noncompliance identified in multiple benefit classifications (e.g., inpatient, outpatient, and prescription drugs),[31] (2) number of enrollees served by the MCO,[32] and (3) the MCOs' use of subcontractors for claims adjudication and denials of service (footnote 14).

We reviewed the State agency's oversight of its MCOs' compliance with parity requirements for MH/SUD services related to prior authorization of those services compared to M/S services in the same benefit classifications. To determine whether MCOs may have imposed limits on certain MH/SUD services requiring prior authorization that were not comparable to, or more restrictive than, those applied to M/S services in the same benefit classifications, we reviewed the selected MCOs' policies and practices as written and in operation related to those services.

We did not review the overall internal control structure of the State agency or the MCOs. Rather we limited our review of internal controls to those applicable to our objective. Specifically, we queried the State agency about its policies and procedures for overseeing and monitoring the MCOs' compliance with parity requirements related to prior authorization; the State agency's followup with MCOs and the corrective actions taken for any identified noncompliance; and the guidance that the State agency has provided to MCOs related to compliance with parity requirements.

We conducted our audit work from November 2024 to May 2026.

METHODOLOGY

To accomplish our objective, we took the following steps:

- Reviewed applicable Federal and State laws and regulations and the State agency's contracts with and guidance to MCOs regarding compliance with parity requirements

[31] We obtained this information from the State agency's parity report, issued January 2024.

[32] We obtained enrollment data from the State agency.

- Met with State agency officials to gain an understanding of the State agency's monitoring policies and procedures to ensure MCOs compliance with parity requirements

- Obtained enrollment data from the State agency for each of its MCOs

- Reviewed the State agency's analyses of MCO parity compliance and its parity reports[33] to determine whether the analyses identified issues of noncompliance with parity requirements, and whether the State agency or MCOs took action to address any issues of noncompliance

- Selected a nonstatistical sample of three MCOs for review based on an analysis of risk factors

- Communicated with the selected MCOs to:

    - gain an understanding of the MCOs' policies for providing MH/SUD benefits to enrollees, specifically for services that require prior authorization

    - review benefit handbooks and other plan records to determine the MCOs' practices as written for providing MH/SUD and M/S benefits that require prior authorization

    - obtain claims denial data and associated MCO records for CY 2023 to review rates of denial for MH/SUD and M/S services requiring prior authorization

    - obtain their comparative analyses and supporting data, if available

    - reconcile claims denial data to MCOs' denial summaries provided to the State agency

- Discussed the results of our audit with State agency officials

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[33] The parity reports evaluated and documented compliance and identified potential parity issues that required corrective action. The State agency used a contractor to prepare these reports to comply with CMS's final rule (81 Fed. Reg. 18390 (Mar. 30, 2016)).

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

Henry McMaster GOVERNOR
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August 17, 2026

Mr. Truman Mayfield
Regional Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services
61 Forsyth Street, SW, Suite 3T41
Atlanta, Georgia 30303

Re: Response to Draft Report A-04-24-07115

Dear Mr. Mayfield:

The South Carolina Department of Health and Human Services (SCDHHS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report titled "*South Carolina Did Not Ensure That Selected Medicaid Managed Care Organizations Complied With Mental Health and Substance Use Disorder Parity Requirements Related to Prior Authorization*," dated July 17, 2026. We appreciate the work of your office and value the opportunity to provide comments on the recommendations presented. SCDHHS is committed to strengthen the monitoring and oversight of Medicaid managed care programs to ensure that contracted MCOs are adhering to all federal, state, and MCO contract requirements so that MCOs are not inappropriately denying care to their Medicaid enrollees.

As the March 2024 OIG audit covered calendar year 2023, SCDHHS would like to emphasize that the agency was already engaged with CMS' Managed Care Group within the Division of Managed Care Operations (DMCO) to address CMS' concerns regarding categorical disparities. This collaboration also involved completing a comprehensive review and analysis of SCDHHS' fee-for-service and managed care program adherence to parity requirements, as well as updating the MCO Contract to establish fully compliant terms and requirements related to mental health parity.

SCDHHS began working with DMCO in November 2023 to establish a compliance timeline and address identified concerns. Together, DMCO and SCDHHS implemented an agreed upon timeline extending through December 2024 and established monthly checkpoints and program updates with CMS and SCDHHS staff. These checkpoints provided SCDHHS the opportunity to report on the status of planned program changes and operational updates necessary to achieve compliance and resolve all concerns. This timeline concluded with SCDHHS submitting a final report and analysis to DMCO on Mental Health and Substance Use Parity across both the fee for service and managed care programs in December of 2024.

Together with the CMS related improvement activities and the present OIG report recommendations, SCDHHS is confident that we have been committed to and steadfastly continuing to strive for a Medicaid

program that delivers appropriate services for our enrollees. Our ultimate goal is to safeguard against any barriers and deficiencies that prevent us from meeting all regulatory expectations.

OIG's recommendations and SCDHHS' responses are below.

OIG Recommendation
SCDHHS should implement policies and procedures for monitoring the MCOs' compliance with parity requirements, including providing clear, uniform guidance to the MCOs regarding maintaining and providing accurate, complete, and consistent data to support the MCOs' quarterly service authorization reports.

SCDHHS Response
SCDHHS concurs with this recommendation and implementation of three significant changes that had already occurred prior to the start of the OIG audit but after the OIG audit period under review.

In July of 2024 SCDHHS enhanced the reporting templates for reporting of service authorization by adding additional fields and data elements. An additional report was added to MCO reporting that required each MCO to submit a listing of authorization requirements by benefit type. Combined, these two enhancements have ensured that our agency has the data it needs to appropriately and comprehensively review MCO data for overall parity and parity concerns specific to NQTLs.

Thirdly, MCO contract language was enhanced to appropriately document the responsibilities of reporting data elements to SCDHHS so that comprehensive review and analysis of the data was possible. The additional contract language was added to the MCO Contract effective July 1, 2024.

OIG Recommendation
SCDHHS should implement policies and procedures for monitoring the MCOs' compliance with parity requirements, including reviewing and validating the MCOs' data that support the MCOs' quarterly service authorization reports, so the State agency can accurately complete and report the parity analyses of MH/SUD services compared to M/S services that require prior authorization.

SCDHHS Response
SCDHHS concurs with this recommendation. The reporting elements and improvements outlined in the response above have allowed SCDHHS to review and validate MCO data that is submitted. The addition of data elements which stratify authorization approvals and denials into MH/SUD or M/S categories allow staff to provide better oversight using more accurate and appropriate reporting elements. This reporting can also be reviewed in conjunction with External Quality Review activities conducted on behalf of SCDHHS by our contracted EQRO vendor.

OIG Recommendation
SCDHHS should implement policies and procedures for monitoring the MCOs' compliance with parity requirements, including addressing with the MCOs any issues of noncompliance or potential noncompliance with parity requirements and coordinating with the MCOs to develop corrective action plans.

SCDHHS Response
SCDHHS concurs with this recommendation. Enhanced reporting and contractual leverage have given SCDHHS the regulatory capability to fully address MH/SUD disparities that occur related to authorization

practices by our contracted Managed Care Organizations. With these enhanced tools SCDHHS will continue to strengthen its oversight responsibilities with our contracted entities. SCDHHS will be working within future EQRO activities and internal oversight procedures to provide appropriate review and feedback, to include addressing any disparity concerns with any MCO that falls outside of MH/SUD requirements, to include corrective action processes.

SCDHHS thanks OIG for their efforts on this issue and looks forward to working with OIG on this and other issues in the future. We remain committed to ensuring that Medicaid enrollees in South Carolina have equitable access to MH/SUD services without unnecessary delays or barriers. We appreciate OIG's collaboration in identifying opportunities for improvement and will continue working diligently to meet all federal parity obligations.

Please do not hesitate to contact us should you need additional information or clarification.

Sincerely,

Eunice Medina
Director

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