

South Carolina Medicaid Managed Care Program

# MEDICAL HOMES NETWORK

*Policy and Procedures Guide*

*2008*



*Building Healthy Families*

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# MEDICAL HOMES NETWORK PROGRAM

## INTRODUCTION

The South Carolina Department of Health and Human Services (SCDHHS) has defined its mission as providing statewide leadership to most effectively utilize resources to promote the health and well being of South Carolinians. The State intends to promote and further its mission by defining measurable results that will improve member access and satisfaction, maximize program efficiency, effectiveness, and responsiveness, and reduce operational and service costs. The following methods are intended to support the achievement of this mission:

- Provide a medical home for Medicaid beneficiaries to promote continuity of care.
- Emphasize prevention and self-management to improve quality of life.
- Supply providers and members with evidence-based information and resources to support optimal health management.
- Utilize data management and feedback to improve health outcomes for the state.

The establishment of a medical home for all Medicaid eligible beneficiaries has been a priority/goal of the SCDHHS for a number of years. The goals of a medical home include:

- Accessible, comprehensive, family centered, coordinated care.
- A medical home with a provider to manage the patient's health care, to perform primary and preventive care services and to arrange for any additional needed care.
- Patient access to a "live voice" 24 hours a day, 7 days a week to ensure appropriate care.
- Patient education re: preventive and primary health care, utilization of the medical home and appropriate use of the emergency room.

In an effort to develop and implement a more responsive, consistent and accountable program model, the SCDHHS has initiated Medicaid medical homes programs through networks of primary care providers - **Medical Homes Networks (MHN)**. **MHN** is Medicaid's Primary Care Case Management (PCCM) program linking Medicaid beneficiaries with a primary care provider (PCP). The PCP works in partnership with the member to provide and arrange for most of the member's health care needs. The outcomes of this medical home initiative will be healthier, better-educated Medicaid beneficiaries and cost savings for South Carolina through a reduction of acute medical care and disease related conditions.

**MHN** members will have care managers who assist in developing, implementing, and evaluating the care management strategies of the Network. These care management strategies include:

- Risk assessment process – utilizing an "at risk" screening tool that identifies both medical and social risk factors.
- Reviewing emergency department utilization – integrating appropriate outreach, follow-up, and educational activities based on emergency department use by members.

- Implementing disease management processes – for example, targeting pediatric and adult asthma, sickle cell anemia, congestive heart failure, and diabetes.
- Implementing a care management process – identifying and targeting care management activities based on the screening process and other methods of identifying those members at risk.
- Identifying high costs and high users – developing and implementing activities that impact utilization and cost.

**Medical Homes Networks (MHN):** A group of physicians, who have agreed to serve as Primary Care Case Management (PCCM) providers, and other health care providers who partner with a Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for members and for managing members' care.

**Care Coordination Services Organization (CSO):** Experienced, responsive, responsible, and financially sound organizations that provide infrastructure and support to the Network physicians. The CSO serves as the designated agent for the Network. For simplicity, SCDHHS will refer to the management entity associated with the Network as a Care Coordination Services Organization (CSO).

**Primary Care Case Management (PCCM):** A system under which a Primary Care Case Manager contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid Beneficiaries.

**Primary Care Provider (PCP):** An individual physician or group medical practice who agrees to serve as the Member's primary physician, contribute to the development and implementation of the care treatment plan, and participate in quality of care initiatives and reviews.

## THE CONTRACT PROCESS

This section will provide the information necessary for preparing to initiate a Medical Homes Network (MHN) contract with the SCDHHS. SCDHHS will furnish potential contractors with a copy of the MHN standards, the Policy and Procedure Guide and the model contract upon request. This contract may also be found on the SCDHHS website at [www.scdhhs.gov](http://www.scdhhs.gov). The model contract has been approved by the Centers for Medicare and Medicaid Services (CMS). The terms of the contract are established and are not negotiable.

SCDHHS will enter into a contract with any qualified Network that meets the SCDHHS standards for Medical Homes Networks. SCDHHS will contract with a Medical Homes Network through the Care Coordination Service Organization (CSO). SCDHHS will not contract with any individual and/or group of individuals having an outstanding debt with the agency. If any member of a group has an outstanding debt against SCDHHS, the entire group will be considered to have same.

The potential contractor should send a letter requesting consideration for participation in the MHN program. The letter should include a statement of purpose, brief company background to include ownership, corporate status, major shareholders and/or company officers, location of network, basic Network structure, and the name of the primary contact. The letter should be addressed to:

Director, Division of Care Management  
South Carolina Department of Health and Human Services  
P.O. Box 8206  
Columbia, South Carolina 29202-8206

Upon receipt of this letter, SCDHHS will provide the applicant details on the application process, including an overview of the MHN standards. The applicant should prepare a thorough written response to demonstrate their ability to meet each standard of operation. A total of six (6) copies (one original and five copies) of the response must be submitted. This becomes the potential contractor's official application packet and should be addressed to:

Team Leader, Department of Managed Care  
South Carolina Department of Health and Human Services  
P.O. Box 8206  
Columbia, South Carolina 29202-8206

The Department of Managed Care will convene a team to review the Application Packet. SCDHHS will notify the applicant of any changes or re-submissions that must be made prior to approval. Concurrent to this review process, the MCO will coordinate with the SCDHHS Division of MMIS to establish connectivity with SCDHHS information systems.

Once the Application Packet has been approved, SCDHHS will mail an Enrollment Package to the applicant. The Enrollment package will contain the following:

1. Two (2) copies of the formal contract
2. Enrollment Form (SCDHHS Form 219-HMO)
3. Minority Business Form
4. Disclosure of Ownership and Controlling Interest Statement
5. Form W-9, Taxpayer Identification Number and Certification
6. Drug Free Workplace Form
7. EFT Authorization Form
8. Certification Relating to Restrictions on Lobbying
9. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower tier Covered Transactions
10. Nonresident Taxpayer Registration Affidavit

The potential contractor should then sign and return both copies of the Contract. Upon approval of all submissions and the establishment of connectivity SCDHHS will authorize its External Quality Review Organization (EQRO) to conduct an on-site Readiness Review of the MHN's South Carolina operation. If deficiencies are noted during the Readiness Review, the MHN must submit a Plan of Correction (PoC) to SCDHHS. The time frames given for correcting the deficiencies will be based on the severity and scope of the deficiencies. The SCDHHS staff will monitor the MHN's progress with its PoC. The purpose of this Readiness Review is to assess the MHN's capacity to begin immediate operations. The MHN is scored against a set of standards that represent SCDHHS' expectations for successful operation within the South Carolina Medicaid Program.

Once the Readiness Review has been completed and the EQRO has submitted its final report to SCDHHS attesting to the MHN's operational readiness, the SCDHHS Managed Care staff will submit contract to CMS for approval. Upon receiving approval from CMS, the appropriate paper work to enroll the MHN in the MMIS system will be submitted. The MHN will be allowed to begin signing up beneficiaries immediately upon final execution of the contract. Members will be enrolled into the Medicaid Managed Care Enrollment System in accordance with established procedures and timelines.

## **THE MEDICAL HOMES NETWORK**

The Network shall be defined as the participating physician practices, any advisory boards, and the CSO. If the network is geographically based, it should be comprised of the normal practice and referral patterns. Geographically based plans are not exclusive and networks cannot prevent providers from participating in other managed care programs; i.e., MCO/PPO etc. If the network is specialty based, it should be comprised of similar types of providers, i.e., Children's Hospitals and their accompanying pediatric practices.

The CSO shall be the designated agent for the Network. Care Coordination Service Organizations (CSO) are to be experienced, responsive, responsible, and financially sound organizations that provide infrastructure and support to the Network and the participating primary care practices.

The State intends to share any documented cost savings with the network utilizing an agreed-upon formula established by independent actuaries contracted by the State. The CSO will be responsible for dividing the Network's share between the participating practices and the CSO, based upon the agreement established between the CSO and the practices. In the event a CSO terminates its contract with SCDHHS, it must allow its network providers to terminate their contract with the CSO, in accordance with the terms of their contract. The CSO may not withhold cost sharing payment if a provider terminates under these above-mentioned circumstances.

The Network will be responsible for components and services as follows:

- Formal Care Coordination and Case Management.
- Service Utilization Management/Track services provided to members
- Member Education.
- Disease Management.
- Provider Education and training on evidence-based medicine and Best Practice protocols.
- Pharmacy Management to include, but not limited to: Benefit Management Oversight and Clinical Risk Identification.
- Exception and performance tracking and reporting.
- Outcomes measurement and data feedback.
- Distribution of any Per Member Per Month care coordination fee to the participating physicians using a SCDHHS approved incentive based formula.
- Distribution of any cost savings.

## **MEDICAL HOMES NETWORK CARE COORDINATION SERVICES ORGANIZATION**

Care Coordination Service Organizations (CSO) provide infrastructure and support to the Network. The CSO will be responsible for providing or ensuring the provision of the following components and services:

- Formal Care Coordination and Case Management.
- Service Utilization Management/Track services provided to members
- Member Education.
- Disease Management.
- Provider Education and training on evidence-based medicine and Best Practice protocols.
- Pharmacy Management to include, but not limited to: Benefit Management Oversight and Clinical Risk Identification.
- Exception and performance tracking and reporting.
- Outcomes measurement and data feedback.
- Distribution of any Per Member Per Month (PMPM) Care Coordination fee to the participating physicians using a SCDHHS-approved incentive based formula.
- Distribution of any cost savings.

The responsibilities the CSO is expected to perform consist of these components:

1. Development, maintenance and expansion of a network of physicians that will assume the responsibility of providing medical homes for Medicaid beneficiaries in their respective regions.
2. Assistance to the MHN to ensure their ability to provide:
  - Care Coordination and Case Management,
  - Disease Management, and
  - Pharmacy oversight and management.
3. Demonstrate budget neutrality or cost savings for services to beneficiaries in the plan.
4. Management of the medical and health care needs of members to assure that all medically necessary services are made available in a timely and cost efficient/effective manner.
5. The monitoring and follow-up on care provided by other medical service providers for diagnosis and treatment, to include externally referred services.

A detailed description of the Scope of Work the CSO shall perform may be found in the Medical Homes Network Standards section.

### **MEDICAL HOMES NETWORK PRIMARY CARE PROVIDERS**

A Primary Care Physician (PCP) is an individual physician or group medical practice who agrees to serve as the Member's primary physician, contribute to the development and implementation of a care treatment plan when appropriate, and participate in quality of care initiatives and reviews. The PCP provides and/or arranges for most of the members' healthcare needs. PCPs are required to either provide services or authorize another provider to treat the member.

South Carolina Medicaid providers who are interested in participating in a MHN should call the SCDHHS Division of Care Management at 803-898-4614 to obtain information

on becoming part of a MHN. The Medical Homes Program Manager will inform the provider of the various Network options available.

SCDHHS will enroll PCPs who are contracted with a Network into the MHN program. The PCP will contract with the CSO/Network. SCDHHS will not contract directly with the PCP.

The following Medicaid provider types may enroll as a **Medical Homes-Primary Care Provider**:

- Family Medicine
- General Practice
- Pediatrician
- Internal Medicine
- OB/GYN
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)

The decision to allow other provider types to join a particular network will be at the discretion of the Network. Other provider types wishing to participate in a Medical Homes Network should petition/contact the local Network. A listing of current Networks may be obtained by calling the Division of Care Management at 803-898-4614.

## **BENEFICIARY ENROLLMENT**

### **Who is eligible to enter an MHN?**

Enrollment in **MHN** is voluntary. All Medicaid eligible beneficiaries may enroll in the program except the following:

- Those enrolled in the Family Planning Waiver.
- Those enrolled in the Medically Fragile Children's Program.
- Those who are institutionalized.
- Those with Limited Medicaid Benefits.
- Those who are enrolled in another Medicaid managed care entity.

Enrollment should be restricted to beneficiaries who reside sufficiently near the delivery site or PCP's practice so that they may reach that site within a reasonable time using available and affordable modes of transportation.

### **How Is Medicaid Eligibility Determined**

Individuals who meet financial and categorical requirements may qualify for Healthy Connections Choices (Medicaid).

The South Carolina Department of Health and Human Services (SCDHHS) determines eligibility for Medicaid. An individual applying for Medicaid as an SSI recipient must apply at the local Social Security office. Generally, an individual who is approved for SSI will automatically receive Medicaid. Applications for all other coverage groups may be filed in person or by mail. Applications may be filed at out-stationed locations such as the county health departments, federally qualified rural health centers, most hospitals and the county Department of Social Services. Applications may be mailed to:

South Carolina Department of Health and Human Services  
Division of Central Eligibility Processing  
Post Office Box 100101  
Columbia, South Carolina 29202-3101

Persons who are approved for Healthy Connections Choices (Medicaid) receive a permanent, plastic Healthy Connections Choices (Medicaid) card. They are instructed to take the card with them when they receive a medical service.

### **Annual Review**

Sixty (60) days prior to the annual review date, the beneficiary is sent a review form to complete.

- (1) If the beneficiary does not return the review form at all, the case is closed and the beneficiary's eligibility is terminated.

- (2) If the beneficiary returns the form incomplete, the form is returned to the beneficiary with a checklist indicating what is missing and how to correct the problem. If the missing information is not received by the next review date, the case is closed 60 days after the original review form was mailed, usually on the next review date.
- (3) If the beneficiary returns the form complete, the date the form was received is entered in MEDS. The worker performs the review. Data from the review form is verified as necessary and a redetermination is made on the case. The case is either approved or closed.
- (4) If the beneficiary returns the form after the case has been closed, the date the form was received will be compared to the closure date. If the received date is less than 30 days after the closure date, the case is reopened and the review is processed as if it had been received on time.

If the beneficiary returns the form more than 30 days after the case has been closed, the review form is treated like a new application. If any additional verification is needed, a checklist is forwarded to the beneficiary. Policy allows up to 45 days to make an eligibility determination on a new application. At this point, the case is either approved or denied.

### **Enrollment Process**

SCDHHS has instituted a new enrollment process for Medicaid managed care called South Carolina Healthy Connections Choices (SCHCC). It is currently operated under contract with MAXIMUS Inc. SCHCC is being implemented by region with a target of May 2008 for statewide implementation. Additional details on SCHCC may be found at [www.scchoices.com](http://www.scchoices.com). Newly eligible Medicaid beneficiaries and beneficiaries going through the yearly eligibility re-determination process who also meet the criteria for Medicaid managed care participation will be informed of their various managed care choices. Before being assigned to a plan by SCHCC, beneficiaries who are eligible for plan assignment are given at least thirty (30) days to choose a plan or decide to remain in the fee-for-service Medicaid program. Beneficiaries not eligible for plan assignment may proactively enroll in a managed care plan (see Payment Categories chart below for a listing of eligibility types and assignment status).

Since South Carolina operates a voluntary managed care system, current Medicaid recipients may enroll at any time with a managed care option. Also, once a person has joined or been assigned to a managed care plan, they have ninety (90) days in which they may transfer to another plan or to fee-for-service Medicaid without cause. After the 90-day choice period has expired, members must remain in their health plan until their one year anniversary date unless they have a special reason to make a change (see disenrollment section for details).

**Contractors may not generate enrollment forms in any SCHCC implemented region. After May 1, 2008, Contractors will not be allowed to generate enrollment forms in any part of the state and enrollment activities will be**

performed by Healthy Connections Choices (for the purposes of this manual, Contractors will be allowed to enroll members in the Pee Dee region during April 2008.)

### **Enrollment Period**

Medicaid **MHN** members shall be enrolled for a period of twelve (12) months contingent upon their continued Medicaid eligibility. The member may request disenrollment without cause at any time during the 90 days following the date of the member's initial enrollment with the **MHN**. A member shall remain in the **MHN** unless the member submits an oral or written request to disenroll or to change managed care plans for cause or unless the member becomes ineligible for Medicaid and/or **MHN** enrollment. If the member makes the request verbally, the Contractor and/or SCDHHS shall confirm the member's wishes by having the member sign a disenrollment form.

The following are considered cause for disenrollment by the member:

- The member moves out of the **MHN's** service area;
- The PCP does not, because of moral or religious objections, cover the service the member seeks;
- The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member's PCP or another provider determines that receiving the services separately would subject the member to unnecessary risk; and
- Other reasons, including but not limited to, poor quality of care, lack of access to services, or lack of access to providers experienced in dealing with the member's health care needs.

The effective date of an approved disenrollment shall be no later than the first day of the second month following the month in which the member or PCCM files the request.

If a member is disenrolled because of losing Medicaid eligibility and regains Medicaid eligibility within 60 days of the disenrollment date, the member will be automatically re-enrolled with the PCP. If this temporary loss of Medicaid eligibility has caused the member to miss his/her annual disenrollment opportunity, the member may request disenrollment following the automatic re-enrollment. If eligibility is regained after 60 days of the disenrollment date, the member will need to complete a new enrollment form in order to be re-enrolled.

Annually, SCDHHS will mail a re-enrollment offer to **MHN** members to determine if they wish to continue to be enrolled with the **MHN**. Unless the member becomes ineligible for the **MHN** or provides written notification that they no longer wish to be enrolled in the **MHN**, the member will remain enrolled with the **MHN**.

Enrollment is limited to 2,500 Beneficiaries (Medicaid MHN members and existing commercial members) per full-time physician, unless otherwise approved by the SCDHHS.

## **Member Disenrollment**

Disenrollments may be initiated by (1) the member, (2) SCDHHS or (3) the Contractor. Member-initiated disenrollment is addressed above in the section entitled **Enrollment Period**. The Contractor may conduct an initial follow up for all voluntary disenrollees. These members will be identified on the member listing file with a special indicator. The Contractor may contact the member upon receipt of the monthly member listing file. However, follow up must be within the guidelines outlined in this guide

Beneficiaries currently enrolled in an MCO (Managed Care Organization) must use the SCDHHS Form 280-2 Managed Care Plan Change Form to disenroll from the MCO prior to being enrolled in an **MHN**. This form is available on the SCDHHS website and may be used to disenroll from any SC Medicaid Managed Care option. If a beneficiary wishes to disenroll from one option and enroll in the **MHN** at the same time, the beneficiary may do so by completing the Managed Care Plan Change Form.

If the beneficiary is within the first 90 days of enrollment with the original plan, no documentation is necessary to support the change in plans. If the beneficiary is in his/her lock-in period, he/she must submit documentation in order for SCDHHS to process the request. Prior to approving the member's request, SCDHHS will refer the request to the Contractor to explore the member's concerns and attempt to resolve them. The Contractor will notify SCDHHS within 30 calendar days of the result of their intervention. The final decision on whether to allow the member's disenrollment rests with SCDHHS, not the Contractor. If a decision has not been reached within sixty (60) days, the member's request to disenroll shall be honored. The beneficiary shall be disenrolled from the first plan effective the last day of the month (depending upon the cut-off cycle) and will be enrolled in the new plan effective the first of the following month.

The SCDHHS will notify the Contractor of the member's disenrollment due to the following reasons:

- ◆ Loss of Medicaid eligibility or loss of Medicaid MHN program eligibility;
- ◆ Death of a Member;
- ◆ Intentional Submission of Fraudulent Information;
- ◆ Becomes an inmate of a Public Institution;
- ◆ Moves out of State;
- ◆ Becomes institutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;
- ◆ Enrollment in the Medically Fragile Children's Program;
- ◆ Loss of Contractor's Participation;
- ◆ Member admitted to a DJJ Community Facility;
- ◆ Enrollment in another MCO through third party coverage; and
- ◆ Enrollment in another Medicaid managed care plan.

The Contractor shall immediately notify SCDHHS when it obtains knowledge of any Medicaid **MHN** Program member whose enrollment should be terminated.

The Contractor shall have the right to contact **MHN** members who have been disenrolled when the reason for disenrollment is "ineligible for Medicaid". This means that Medicaid eligibility has been terminated.

The Contractor may request to disenroll a Medicaid **MHN** Program member based upon the following reasons:

- Contractor ceases participation in the Medicaid MHN program or in the Medicaid **MHM** Program member's service area;
- Medicaid **MHN** Program member dies;
- Becomes an inmate of a Public Institution;
- Moves out of State;
- Becomes Institutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;
- Becomes enrolled in the Medically Fragile Children's Program;
- Member admitted to a DJJ Community Facility; and
- Fails to follow the rules of the managed care plan.

The Contractor's request for member disenrollment must be made in writing to SCDHHS using the SCDHHS Form 280-2 Managed Care Plan Change Form or, when appropriate, utilizing the Plan Initiated Disenrollment Request Form provided by Health Connections Choices and the request must state the detailed reason for disenrollment. The request must also include documentation verifying any change in the member's status. Within ten working days, SCDHHS will determine if the Contractor has shown good cause to disenroll the member and SCDHHS will give written notification to the Contractor and the member of its decision. The Contractor and the member shall have the right to appeal any adverse decision.

The Contractor shall not terminate a member's enrollment because of any adverse change in the member's health except when the member's continued enrollment in the MHN would seriously impair the Plan's ability to furnish services to either this particular member or other members. On occasion, it may become necessary to disenroll a **MHN** member from a practice due to good cause. According to the guidelines listed in the South Carolina State Plan for Medical Assistance that allows operation of the **MHN** program, good cause is defined as:

- Behavior on the part of the member which is disruptive, unruly, abusive or uncooperative to the extent that the ability of the provider to provide services to the member or other affected members is seriously impaired;
- Persistent refusal of a member to follow a reasonable, prescribed course of treatment; or
- Fraudulent use of the Medicaid card.

To disenroll a member, the PCP must follow these procedures:

- Notify the **MHN** member in writing of his/her disenrollment. Specify the reason for disenrollment in the letter. Provide 30 days notice. Advise the member to contact the CSO to choose a new PCP or Managed Care Enrollment to choose a new plan.

- Fax a copy of the disenrollment letter to the Department of Managed Care Enrollment at (803) 255-8201 or to the **Medical Homes** Program Manager at (803) 255-8232.

The PCP is encouraged to refer uncooperative, non-compliant patients to the Network's Care Coordinator prior to disenrolling the patient. The Network/CSO will furnish the PCP with the care coordination protocol.

*Note: Until the member's name on the PCP's member listing is reflected as "Disenrolled", the PCP should continue to provide services to the member or authorize another provider to treat the member.*

<b>Guidelines for Involuntary Member Disenrollment</b>	
<b>Reason for Involuntary Disenrollment</b>	<b>Disenrollment Effective Date</b>
Loss of Medicaid eligibility	Member will be auto-disenrolled during the next processing cycle.
Death of Member	Leave enrollment through the month of death. Member will be disenrolled at the end of the month of death. Any premiums for months following the month of death will be recouped.
Intentional submission of fraudulent information	Member will be disenrolled at the earliest effective date allowed.
Member becomes inmate* of public institution	Leave enrollment through the month of incarceration. Member will be disenrolled at the end of the month of incarceration. Any premiums for months following the month of incarceration will be recouped.
Member moves out of state	Leave enrollment through the month the member moves out of state. Member will be disenrolled at the end of the month of the move. Any premiums for months following the month of the move will be recouped.
Member in LTC/NH >30 days	Member will be disenrolled at the earliest effective date allowed by system edits.
Member enters Medically Fragile Children's Program (MFCP)	Member will be disenrolled at the earliest effective date allowed by system edits.
Loss of Contractor's participation	Member will be disenrolled based on MHNs termination date
Member enrolled in another MCO through third party liability	Leave enrollment until the month of private MCO coverage. Member will be disenrolled at the end of the month of new enrollment. Any premiums for months following the month of enrollment in private MCO or other Medicaid managed care plan coverage will be recouped.
Member fails to follow rules of managed care plan.	Member will be disenrolled at the earliest effective date allowed by system edits.
Member admitted to a DJJ Community Facility	Member will be disenrolled beginning the first day of the month they entered the Facility. Any premiums that were paid will be recouped.
<p><i>All disenrollments are subject to the MMIS cutoff date.</i></p> <p><i>*Inmate is defined as a person incarcerated in or otherwise confined to a correctional institution (i.e., jail). This does not include individuals on Probation or Parole or who are participating in a community program.</i></p>	

## **MEMBER BENEFITS**

### **Physician Services**

Physician services include the full range of preventive care services, primary care medical services and physician specialty services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care and treatment of the specific condition. Physician services are performed at physician's offices, patients' homes, clinics and skilled facilities. Technical services performed in a physician's office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service. There is no limit on ambulatory visits for adult MHN members.

### **Early & Periodic Screening, Diagnosis and Treatment (EPSDT)/Well Child**

The EPSDT program provides comprehensive and preventive health services to children through the month of their 21<sup>st</sup> birthday. The program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required healthcare services; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources.

The MCO will assure that the EPSDT program contains the following benefits:

- Comprehensive Health and Developmental History
- Comprehensive Unclothed Physical Exam
- Appropriate Immunizations
- Laboratory Tests
- Lead Toxicity Screening
- Health Education
- Vision Services
- Dental Services
- Hearing Services

The MCO is responsible for assuring that children through the month of their 21<sup>st</sup> birthday are screened according to the American Academy of Pediatrics (AAP) periodicity schedule (<http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf>).

### **Communicable Disease Services**

An array of communicable disease services are available to help control and prevent diseases such as TB, syphilis, and other sexually transmitted diseases (STD's) and HIV/AIDS. Communicable disease services include examinations, assessments, diagnostic procedures, health education and counseling, treatment, and contact tracing, according to the Centers for Disease Control (CDC) standards. In addition, specialized outreach services are provided such as Directly Observed Therapy (DOT) for TB cases.

Eligible beneficiaries should be encouraged to receive TB, STD, and HIV/AIDS services through their primary care provider or by appropriate referral to promote the integration/coordination of these services with their total medical care. Eligible beneficiaries have the freedom to receive TB, STD and HIV/AIDS testing and counseling services from any public health agency without any restrictions to services.

### **Family Planning Services**

An array of family planning services is available to help prevent unintended or unplanned pregnancies. Family planning services include examinations, assessments, diagnostic procedures, health education and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics, and pharmacies. Covered services include traditional contraceptive drugs and supplies and preventive contraceptive methods. Family planning services are also available through special teen pregnancy prevention programs. Services performed in an outpatient hospital setting are considered to be Family Planning services only when the primary diagnosis is "Family Planning."

Eligible beneficiaries should be encouraged to receive family planning services through their primary care provider or by appropriate referral to promote the integration/coordination of these services with their total medical care. However, eligible beneficiaries have the freedom to receive family planning services from any appropriate Medicaid providers without any restrictions.

### **Care Coordination**

Care Coordination is comprised of all activities performed on behalf of the members with special health care needs to coordinate and monitor their treatment for specific identified chronic/complex conditions and diseases and to educate the member to maximize appropriate self-management. The Care Coordinator is responsible for assuring that members receive all needed and appropriate services through their PCP and appropriate specialty and/or ancillary services providers.

### **Member Education**

As the coordinator of care, the Network (CSO and PCP) must be actively involved in member education. The CSO will provide the PCP with a monthly listing of all new enrollees.

Each new member must receive an orientation during which the following subjects are addressed:

- The PCP's requirement to provide medical advice and care 24 hours per day, 7 days per week and the preferred method for contacting the PCP.
- The member's responsibility to bring his/her Medicaid card to each appointment.

- The member must contact the PCP for a referral before going to any other doctor.
- The member should be encouraged to contact the PCP before going to the emergency department unless the member feels that his/her life or health is in immediate danger.
- The importance of regular preventive care visits such as EPSDT screening for children, immunizations, checkups, mammograms, cholesterol screenings, adult health assessments, and diabetic screenings.

### **Member Services**

The Network shall maintain an organized, integrated member services function to assist Medicaid **MHN** members in understanding the program's policies and procedures. Member Services can provide additional information about the Network's primary care providers, facilitate referrals to participating specialists, and assist in the resolution of service and/or medical delivery concerns or problems a Medicaid **MHN** member may have. The Network shall identify and educate Medicaid **MHN** members who access the system inappropriately and provide additional education as needed.

The Network shall demonstrate its commitment to member services by establishing a member services department/unit that can assist in the education of Medicaid **MHN** members. The Network shall provide a written description of its member services function to give to its Medicaid **MHN** members no later than fourteen (14) business days from receipt of enrollment data from SCDHHS.

The written description must include information on the following:

- The appropriate utilization of services
- How to access services;
- How to select a primary care physician;
- Access to out-of-plan care;
- Emergency care (in or out-of-area);
- The process for prior authorization of services;
- Toll free telephone number for member services;
- Written explanation containing a Statement of Understanding authorizing the provider to release medical information to the federal and state governments or their duly appointed agents.

Members' rights are outlined in the Bill of Rights section.

## MEDICAL HOMES NETWORK PROVIDER REQUIREMENTS

Primary Care Providers who enter into a contract with a **Medical Homes Network** will be expected to meet certain conditions. The CSO will be responsible for ensuring that providers meet these conditions:

1. The practice must be willing to accept new Medicaid patients not to exceed the practice's established capacity.
2. The practice must provide primary care and patient care coordination services to each member.
3. The practice must provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. (See **24-Hour Coverage Requirement**)
4. The practice must provide preventive services as defined by the network.
5. The practice must offer general patient education services to all members and potential members as well as disease management services to members for whom the services are appropriate.
6. **MHN** PCPs must establish and maintain hospital admitting privileges or enter into an arrangement with another physician or group practice for the management of inpatient hospital admissions of **MHN** members. (See **Hospital Admitting Privileges Requirement**)
7. The practice will assist the member by providing systematic, coordinated care and will be responsible for all referrals for additional medically necessary care to other health care providers.
8. The practice will be required to follow the recommended Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening schedules, as required by the Centers for Medicare and Medicaid Services (CMS). [See **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**]
9. The practice will be required to utilize the following standards for Appointment Availability:
  - Emergency care – immediately upon presentation or notification
  - Urgent care – within 48 hours of presentation or notification
  - Routine sick care – within 3 days of presentation or notification
  - Routine well care – within 45 days of presentation or notification (15 days if pregnant)
10. The practice will be required to utilize the following standards for office visit times
  - Walk-ins – within two hours or schedule an appointment within the standards of appointment availability listed above
  - Scheduled appointment – within 45 minutes
  - Life-threatening emergency – must be managed immediately

Failure to meet these requirements could result in the imposition of sanctions on the PCP, the CSO, and/or the Network as a whole. Providers' rights are detailed in the Bill of Rights section.

**24-Hour Coverage Requirement**

**MHN** requires PCPs to provide access to medical advice and care for enrolled members 24 hours per day, 7 days per week. There must be prompt (within one hour) access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

PCPs must provide members with an after-hours telephone number. The after-hours telephone number must connect the member to:

- An answering service that promptly contacts the PCP or the PCP-authorized medical practitioner; or
- A recording that directs the caller to another number to reach the PCP or the PCP-authorized medical practitioner; or
- A system that automatically transfers the call to a telephone line that is answered by a person who will promptly contact the PCP or the PCP-authorized medical practitioner; or
- A call center system; or
- The PCP's home telephone number, if he/she so chooses.

A hospital may be used for the 24-hour telephone coverage requirement under the following conditions:

- The 24-hour access line is not answered by the emergency department staff.
- The PCP establishes a communication and reporting system with the hospital.
- The PCP reviews results of all hospital-authorized services.

An office telephone line that is not answered after hours or answered with a recorded message instructing members to call back during office hours or to go to the emergency department for care is not acceptable. Additionally, it is not acceptable to refer members to a telephone number if there is no system in place as outlined above to respond to calls. PCPs are encouraged to refer patients with after-hours urgent medical problems to an urgent care center rather than the emergency room, provided there is one accessible to the members.

**Standards of Appointment Availability**

PCPs must conform to the following standards for appointment availability:

- Emergency care – immediately upon presentation or notification
- Urgent care – within 48 hours of presentation or notification
- Routine sick care – within 3 days of presentation or notification
- Routine well care – within 45 days of presentation or notification (15 days if pregnant)

### **Standards for Office Wait Times**

PCPs must conform to the following standards for office wait times:

- Walk-ins – within two hours or schedule an appointment within the standards of appointment availability listed above
- Scheduled appointment – within 45 minutes
- Life-threatening emergency – must be managed immediately

### **Hospital Admitting Privileges Requirement**

**MHN** PCPs must establish and maintain hospital admitting privileges or enter into a formal arrangement with another physician or group practice for the management of inpatient hospital admissions of **MHN** members. A voluntary written agreement between the **MHN** PCP and a physician or group who agrees to admit **MHN** members for the PCP fulfills this requirement for participation. By signing such an agreement, the physician/group agrees to accept responsibility for admitting and coordinating medical care for the member throughout the member's inpatient stay. **This agreement must be completed by both parties.** The CSO must keep the original of this document on file. A sample admission agreement can be found in the Forms section.

The following arrangement is acceptable:

- A physician, a group practice, a hospital group, a physician call group (not necessarily a **MHN** provider) that is enrolled with the South Carolina Medicaid program, and has
- Admitting privileges or formal arrangements at a hospital that is within 30 miles or 45 minutes drive time from the PCP's office. If there is no hospital that meets this geographic criteria, the closest hospital to the **MHN** PCP practice is acceptable.

Hospital admitting agreements with unassigned call doctors are unacceptable.

Exceptions may be granted in cases where it is determined the benefits of a PCP's participation outweighs the PCP's inability to comply with the admitting privileges requirement.

### **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)**

**MHN** PCPs are required to provide EPSDT screening to Medicaid-eligible children under the age of 21. The EPSDT standards are:

1. To provide **EARLY** health assessments of the child who is Medicaid eligible so that potential diseases can be prevented.
2. To **PERIODICALLY** assess the child's health for normal growth and development.
3. To **SCREEN** the child through simple tests and procedures for conditions needing closer medical attention.
4. To **DIAGNOSE** the nature and cause of conditions requiring attention, by synthesizing finds of the health history and physical examination.

5. To **TREAT** abnormalities detected in their preliminary stages or make the appropriate referral whenever necessary.

The screening package includes:

- A comprehensive health and developmental history, including assessment of both physical and mental health development.
- A comprehensive unclothed physical examination.
- Appropriate immunizations according to age and health history.
- Laboratory tests, including blood level assessments appropriate for age and risk factors.
- Health education, including anticipatory guidance.
- Vision and hearing screening.
- Anemia screening.
- Blood Pressure.
- Lead screening.
- Dental screening.
- Lead Toxicity Screening - All children are considered at risk and must be screened for lead poisoning. CMS requires that all children receive a screening blood lead test at 12 months and 24 months of age. Children between the ages of 36 months and 72 months of age must receive a screening blood lead test if they have not been previously screened for lead poisoning. A blood lead test must be used when screening Medicaid-eligible children. A blood lead test result equal to or greater than 10 ug/dl obtained by capillary specimen (fingerstick) must be confirmed using a venous blood sample.

Periodic Screening, Vision, and Hearing services must be provided at intervals that meet reasonable standards of medical practice. States must consult with recognized medical organizations involved in child health care in developing reasonable standards.

Dental services must be provided at intervals determined to meet reasonable standards of dental practice. States must consult with recognized dental organizations involved in child health care to establish those intervals. A direct dental referral is required for every child in accordance with each states periodicity schedule and at other intervals as medically necessary. The periodicity schedule for other EPSDT services may not govern the schedule for dental services. It is expected that older children may require dental services more frequently than physical examinations.

The most current Recommended Childhood Immunization Schedule and EPSDT Screening Age Guidelines are available through the Centers for Disease Control and Prevention ([www.cdc.gov](http://www.cdc.gov)).

## **Adult Preventive Health Assessments**

**MHN** PCPs are expected to provide all of the components of an initial preventive health assessment and periodic assessments to adult members age 21 and over. Adult physical exams are covered under the following guidelines:

- The exams are allowed/performed once every five (5) years per patient.
- The patient is 21 years of age or older.
- Procedure codes 99385-99387 for the appropriate age and diagnosis code V70.9 are used.

## **Women, Infants, and Children (WIC) Program Referrals**

Federal law mandates coordination between Medicaid Managed Care programs and the WIC program. **MHN** PCPs are required to refer potentially eligible members to the WIC program. Sample copies of the **WIC Referral Form** and, the **Medical Record Release form** are available in the Forms section.

For more information, contact the local WIC agency at the county health department.

## **Transfer of Medical Records**

**MHN** PCPs must transfer the member's medical record to the receiving provider upon the change of the PCP and as authorized by the member within 30 days of the date of the request.

## **Medical Records Guidelines**

Medical records should reflect the quality of care received by the patient/member. In order to promote quality and continuity of care, the following guidelines are given as the standards for medical record keeping. These guidelines are intended for **MHN** PCPs.

It is expected that the medical record should include the following for the benefit of the patient and the physician:

1. Each page, or electronic file in the record, contains the patient's name or patient's Medicaid identification number.
2. All entries are dated.
3. All entries are identified as to the author.
4. The record is legible to someone other than the writer, including the author.
5. Medication allergies and adverse reactions are prominently noted and easily identifiable as well as the absence of allergies.
6. Personal and biographical data is recorded and includes age, sex, address, employer, home and work telephone numbers, and marital status.
7. Past medical history is easily identified including serious accidents, operations, and illnesses. For children, past medical history includes prenatal care and birth.
8. There is a completed immunization record. For pediatric patients (ages 12 and under) there is a complete record with dates of immunization administration.

9. Diagnostic information, medication, medical conditions, significant illnesses, and health maintenance concerns are recorded in the medical record.
10. Notation concerning smoking, alcohol, and other substance abuse is present.
11. Notes from consultations are in the record. Consultation, lab, and X-ray reports filed in the chart have the ordering provider's initials or other documentation signifying review. Consultation and significantly abnormal lab and imaging results have an explicit notation in the record of the follow-up plans.
12. Emergency care is documented in the record.
13. Discharge summaries are included as part of the medical record for all hospital admissions that occur while the patient is enrolled with **MHN**.
14. Documentation of individual encounters that provide adequate evidence of appropriate history, physical examination, diagnosis, diagnostic tests, therapies, and other prescribed regimens, follow-up care, referrals and results thereof, and all other aspects of patient care, including ancillary services

## **BEST PRACTICES**

The goal of this section is to give the **MHN** examples of best practices by the South Carolina Medicaid Program. These practices have addressed issues that are particularly prevalent in the South Carolina Medicaid population.

### **Asthma Education and Management**

Development of asthma in children is influenced by interactions between genetic and environmental factors. Asthma cannot be cured but can be controlled. An asthma management program will include but not limited to:

- Education program for child and parent/guardian
- Medication Education / Usage
- Prevention of Attacks
- Rescue Program
- Hospitalization Utilization / Monitoring
- Disease Management

Reference guidelines: the CDC's National Asthma Control Program – Healthy People 2010 for asthma. The goals of the program are to reduce the number of deaths, hospitalizations, emergency department visits, school or work days missed, and limitations on activity due to asthma.

### **Enhanced Prenatal And Newborn Care**

The problem of high infant mortality/morbidity rates has plagued South Carolina for decades. Low income women and infants are over-represented in these rates. The South Carolina Medicaid program is committed to the concept(s) of risk appropriate care and enhancing maternal and child health outcomes. The following Medicaid Best Practice Guidelines are recommended:

1. Early and continuous risk screening for all pregnant women.
2. Early entry into prenatal care and Care Coordination.
3. Care for all prenatal women by the provider level and specialty best suited to the risk of the patient (Guidelines for Perinatal Care, most current edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists.)
4. All infants should receive risk-appropriate care in a setting that is best suited to the level of risk presented at delivery. (Guidelines for Perinatal Care, most current edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists.)

5. Risk assessment of the infant prior to discharge from the hospital.
6. Every Medicaid eligible mother and infant should receive a postpartum/infant Home Visit (PP/HV) service.
7. Communication/Coordination regarding the perinatal plan of the care between each provider (i.e., the specialist physician should communicate pertinent information back to the community level physician).
8. A medical home for both the mother and infant after delivery to handle the long-term health care needs.

For additional recommendations and guidelines for risk appropriate ambulatory perinatal care for pregnant women, *Guidelines for Perinatal Care*, most current edition, American Academy of Pediatrics and American College of Obstetricians and Gynecologists, may be referenced. **(SCDHHS bears no responsibility for furnishing providers copies of these guidelines).**

#### **Other Services:**

Each Medicaid eligible pregnant woman should be assessed to assure that the patient receives all appropriate services that are available. Such services may include Women Infants and Children (WIC), mental health services, Family Planning Services (FPS), or other appropriate health or community services to assure good birth outcomes.

#### **Immunizations**

The administration of immunizations is a required component of EPSDT screening services. An assessment of the child's immunization status will be made at each screening and immunizations administered as appropriate. If the child is due for an immunization, it must be administered at the time of the screening. However, if illness precludes immunization, the reason for delay will be documented in the child's record. An appointment will be given to return for administration of immunization at a later date.

Immunization of children will be provided according to the guidelines recommended by the South Carolina Department of Health and Environmental Control (DHEC), the Centers for Disease Control (CDC) – Advisory Committee on Immunization Practices (ACIP), the American Academy of Family Physicians (AAFP), The American Academy of Pediatrics (AAP), and South Carolina state law.

If a provider does not routinely administer immunizations as part of his/her practice, he/she will refer the child to the county health department and maintain a record of the child's immunization status.

## Early Childhood Immunizations

Immunization of children in the first two years of life is one of the most widely accepted strategies for improving the public's health. Conformance with guidelines is, therefore, a high priority in assuring pediatric health.

1. Childhood immunizations are to follow the current year's schedule as set by the AAP (<http://www.aap.org/healthtopics/immunizations.cfm>). An instant Childhood immunization scheduler is available at the following CDC website: [http://www2a.cdc.gov/nip/kidstuff/newscheduler\\_le/](http://www2a.cdc.gov/nip/kidstuff/newscheduler_le/)
2. Performance Goals: Although the ultimate goal of an immunization effort is 100% immunization compliance, the SCDHHS shall adopt the goal established by South Carolina Department of Health and Environmental Control which is to appropriately immunize 90% of children by the age of 24 months.

## Sickle Cell Anemia Services

To receive services, beneficiaries must be diagnosed through laboratory testing as having Sickle Cell Disease and/or Sickle Cell Trait. Beneficiaries of all ages are eligible.

The Sickle Cell Anemia Program consists of Case Management services and Genetic Education/Family Planning services. The Case Management service includes assessment, service planning, patient monitoring and reassessment. Genetic Education/Family Planning services cover the establishment of a health, social, and genetic history record and the provision of educational services regarding family planning.

The Enhanced Maternal Services include both psycho-social and health education interventions, intended to promote favorable pregnancy outcomes.

The primary objective of the Sickle Cell Program is to enable beneficiaries with Sickle Cell Disease and/or Trait to have timely access to a full array of needed community services and programs that can best meet their needs.

The James R. Clark Memorial Sickle Cell Foundation in Columbia, Louvenia D. Barksdale Sickle Cell Foundation in Spartanburg, The Committee on Better Racial Assurance in Charleston, and the Medical University of South Carolina in Charleston are providers of Sickle Cell Anemia Services. The Department of Health and Environmental Control (DHEC) may be accessed for service interventions for children under the age of 48 months.

## **Children With Chronic/Complex Health Care Needs**

Medical Homes Networks will address the needs of medically challenged children within the context of their family, building on the best of tradition while moving into the paradigm of best practice consistent with health care reform.

South Carolina Medicaid encourages close collaboration between all disciplines serving children with chronic conditions. The goals are to develop a service continuum that is accessible and family friendly. As the comprehensive medical home for children with (or at risk of developing) serious disabling conditions, MHNs will consider including the following services within their protocol of diagnostic and treatment services:

- ▶ Social work
- ▶ Health education
- ▶ Nutrition counseling

Two federally-funded resources for children with special needs include BabyNet and Children's Rehabilitative Services. Usually Medicaid is the "Payer of Last Resort". However BabyNet and Children's Rehabilitative Services (CRS) are federally-funded programs that require Medicaid make payment before they do.

Therefore the payment order for these two programs is:

1. Third Party Liability;
2. Medicaid; then
3. BabyNet or CRS.

Early Intervention Services offered through the Department of Disabilities and Special Needs serves as another resource for special needs children.

### **BabyNet**

BabyNet is South Carolina's single point of entry into a system of coordinated early intervention services. (Also known as Part C of Federal Law IDEA, Individuals With Disabilities Education Act.) Appropriate referrals include infants and toddlers (birth to age 3) who are experiencing developmental delays and/or who have one of the following conditions:

- Chromosomal abnormality
- Genetic disorder
- Growth disturbance secondary to chronic illness
- Severe sensory impairment
- Developmental disorder secondary to exposure to toxic substance
- Inborn error of metabolism
- Severe attachment disorder (psychological required)
- Abnormal development of the nervous system
- Complications of prematurity (ECMO,  $\leq$  1000 grams, or Grade III or IV intraventricular hemorrhage only)

Referral may be made to a BabyNet Service Coordinator by contacting your local DHEC Health District. The BabyNet Service Coordinator and a local multi-disciplinary team identify the most appropriate service coordinator to guide the family through procedures, agencies and services. Eligibility and service provision are established based on each child's identified developmental delay.

### **Children's Rehabilitative Services (CRS)**

With the support of federal, state, and other funding, CRS operates a statewide network of children's medical services. By coordinating the efforts of local, regional, and state resources, CRS assures that the best possible medical services are available across the state for these special children. The CRS System of Care provides nursing intervention, social work services, nutrition services, parent-to-parent support, in and out-patient hospitalizations, braces, hearing aids, specialized medical equipment, physical, occupational and speech therapies, and genetic services. Community based care is provided in the 8 public health regions around the state.

To participate in the CRS program, a child must be a legal resident of the United States, live in South Carolina, be under 21 years old, be diagnosed with a covered medical condition, and the family must meet certain income guidelines. Financial eligibility for program services is based on family size, income, and federal guidelines that are updated annually.

**Covered Conditions and Diagnoses:** CRS offers treatment and services for many disabilities, some of which are listed below:

- Bone and joint diseases;
- Hearing disorders and ear disease;
- Cleft lip and palate and other craniofacial anomalies;
- Spina Bifida and other congenital anomalies;
- Epilepsy (seizures), cerebral palsy and other central nervous system disorders;
- Rheumatic fever;
- Problems from accidents, burns, and poisoning;
- Endocrine disorders;
- Hemophilia (children and adults);
- Sickle cell disorders (children and adults);
- Developmental delays such as speech/language, motor and growth abnormalities; and
- Kidney diseases.

### **Covered Services Nursing**

- Pharmacy
- Durable Medical Equipment
- Physician Services

- Social Work
- Nutrition
- Genetics
- Transition
- Parent-to-Parent Support

### **Services Not Covered**

- Routine visits to your family doctor or pediatrician;
- Routine dental care;
- Emergency room treatment;
- Transportation; and
- Medical services not related to the CRS covered health problem.

### **Early Intervention (EI) Services**

Early Intervention (EI) services provided by the Department of Disabilities and Special Needs (DDSN) serves children (Ages 0 to 6) and families who meet the eligibility criteria for DDSN. This criterion includes children with a diagnosis of autism, head injury, spinal cord injury and similar disabilities, and mental retardation and related disabilities.

The Disabilities and Special Needs Board in each county serves as the planning and service coordination point for the delivery of EI services. Service provision includes family training and service coordination.

Referrals may be made through BabyNet by contacting your local Disabilities and Special Needs Board.

### **Diabetes Education and Management**

The primary objectives of any diabetes education and management interventions are to help the beneficiary adapt to the chronic diagnosis of Diabetes, learn self-management skills, educate the beneficiary and families as to the nature of diabetes, and make important behavioral changes in their lifestyle. MHNs will reference the American Diabetes Association (ADA) guidelines and practices.

### **Prevention And Management Of Sexually Transmitted Diseases**

The MHN will follow the Centers for Disease Control and Prevention (CDC) (<http://www.cdc.gov/std/program>) program guidelines on the prevention, treatment and management of Sexually Transmitted Diseases (STD) and will coordinate with the local health departments (as per State and Federal laws) when members are identified as having contracted or been exposed to an STD.

## **Heart Disease Education and Management**

Heart disease is the leading cause of death in the United States and is a major cause of disability. Heart disease is a term that includes several more specific heart conditions. Education and Management of heart disease will include but not be limited to:

- Lifestyle changes: stop smoking, diet low in fat / cholesterol and high in fiber, maintain a healthy weight and get regular exercise,
- Control Cholesterol
- Control High Blood pressure
- Control Diabetes

The MCOs will follow the CDC guidelines (<http://www.cdc.gov/heart/disease/>) and the American Heart Association (<http://www.americanheart.org>).

## MEDICAL HOMES NETWORK REFERRALS AND AUTHORIZATIONS

Coordination of care is an essential component of the **MHN**. PCPs are contractually required to either provide medically necessary services or authorize another provider to treat the member. If a member has failed to establish a medical record with the PCP, the CSO, in conjunction with the PCP, should arrange for the prior authorization on any existing referral. **Prior Authorization is the responsibility of the PCP/CSO, not SCDHHS.** The Network, at its discretion, may centralize the authorization/referral process for the convenience of the member practices. The Network is encouraged to design an authorization/referral protocol that will be used by all member practices. In some cases, the PCP may choose to authorize a service retroactively. Some services do not require authorization. (*Refer to the list of exempt services* in this section) All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. The process for referring a member to a specialist can be made by telephone or in writing. The referral should include:

- The number of visits being authorized
- The extent of the diagnostic evaluation.

If the PCP authorizes multiple visits for a course of treatment specific to the diagnosis, the specialist does not need to obtain additional authorizations for each treatment visit. The same authorization referral number may be used for each treatment visit. It is the PCP's responsibility to provide any further diagnosis, evaluation or treatment not identified in the scope of the original referral or to authorize additional referrals.

If the specialist receives authorization to treat a member and then needs to refer the member to a second specialist for the same diagnosis, the member's PCP must be contacted for authorization.

Authorization is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the **physician component for inpatient services does require authorization**. The hospital should contact the PCP for authorization within 48 hours of the member's admission. Specialist referrals for follow-up care after discharge from a hospital **also** require PCP authorization.

In addition to **MHN** authorization, prior approval (PA) may be required by SCDHHS to verify medical necessity before rendering some services. PA is for medical approval only. Obtaining PA does not guarantee payment or ensure beneficiary eligibility on the date of service.

Claims submitted for reimbursement must include the PCP's authorization number.

The following services must be authorized by the PCP:

1. Inpatient hospital<sup>1</sup> services except newborn DRGs, Residential Treatment Facilities and Institutions for Mental Disease;
2. Outpatient hospital services except lab and x-ray<sup>2</sup>;

3. All other physicians services except obstetrics, gynecological services, and Family Planning Services;
4. Podiatrists and Chiropractors;
5. Nurse Practitioners and Nurse Midwives except for Family Planning Services;
6. DHEC Clinics except for Family Planning Services and Communicable Diseases;
7. Ambulatory Surgical Centers except for Family Planning Services;
8. FQHC and RHC except for Family Planning Services (unless the FQHC/RHC is the member's MHN PCP);
9. Home Health; and,
10. Durable Medical Equipment.

<sup>1</sup>FQHCs/RHCs that provide inpatient hospital services under a separate provider number (not the FQHC/RHC number) must enter a preauthorization number on the claim form or the claim will reject.

<sup>2</sup>FQHCs/RHCs that provide lab and x-ray services under a separate provider number (not the FQHC/RHC number) must enter a preauthorization number on the claim form or the claim will reject.

### **Referrals for a Second Opinion**

MHN PCPs are required to refer a member for a second opinion at the request of the member when surgery is recommended.

### **Referral Documentation**

All referrals must be documented in the member's medical record. The CSO and the PCPs should review the monthly referral data to ensure that services rendered to their members were authorized and have been documented and recorded accurately in the member's medical record. It is the PCP's responsibility to review the Referral data for validity and accuracy and to report inappropriate/unauthorized referrals to the CSO. The CSO will be responsible for investigating the inappropriate/unauthorized referrals and notifying SCDHHS if Medicaid fraud or abuse is suspected.

### **Exempt Services**

Members can obtain the following services from Medicaid providers without first obtaining authorization from their PCPs:

- Ambulance
- Dentist
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services billed by the Hospital
- Family Planning Services
- Home and Community Based Waivers
- Independent Lab and X-ray<sup>1</sup>
- Medical Transportation
- Nursing Home
- Obstetricians and Gynecologists
- Opticians
- Optometrists

- Pharmacy
- Services from most other State Agencies: Department of Mental Health, Continuum of Care, Department of Alcohol and Other Drug Abuse Services, Department of Disabilities and Special Needs, Department of Juvenile Justice, Department of Social Services.
- Speech and Hearing Clinics
- Developmental Evaluation Centers
- BabyNet
- Children's Rehabilitative Services
- Sickle Cell Anemia Services
- Early Intervention Services

<sup>1</sup> FQHCs/RHCs that provide lab and x-ray services under a separate provider number (not the FQHC/RHC number), must enter a preauthorization number on the claim form or the claim will reject.

Some services still require a prescription or doctor's order. Physicians should refer to the appropriate Medicaid Provider Manual for more detailed information and/or requirements or contact the Program Manager.

Some services may be sponsored by a State Agency and will require a referral from that agency's case manager. The State Agency case manager should coordinate with the PCP and the Network Care Coordinator to insure continuity of care. These services include, but are not limited to, the following:

- Audiologist
- High/Moderate Management Group Homes
- Occupational Therapist
- Physical Therapist
- Psychologist
- Speech Therapist
- Therapeutic Foster Care

## MARKETING

Medical Home providers, in conjunction with the Network Board, are encouraged to develop and implement a written marketing plan designed to provide the Medicaid applicant/beneficiary with information about the Medical Homes program. Any marketing and enrollment materials that explain the program's benefits must contain the 1-888-549-0820 telephone number of the statewide Medicaid Managed Care Enrollment Help Line and the MHN's toll free number. Please note that **all enrollment activities** currently performed by Contractors in a region of the state shall cease upon the expansion of the enrollment broker into that region. All regions are projected to be served by the enrollment broker by May 1, 2008.

The following guidelines will apply to marketing activities conducted by the network:

The **MHN** may not enroll members or conduct enrollment activities in any region that is served by the enrollment broker.

All marketing and/or enrollment procedures and activities must receive prior written approval from SCDHHS or its designee.

The **MHN** may not market directly to Medicaid applicants/beneficiaries in person or through direct mail advertising or telemarketing.

The **MHN** may not conduct door-to-door, telephonic or other "cold call" marketing and/or enrollment activities, either directly or indirectly. The **MHN** cannot make repeated follow up calls unless specifically requested by the Medicaid beneficiary. Repeated unsolicited contacts are prohibited.

**MHNs** cannot utilize any governmental facility, program or procedures in marketing or enrollment activities for Medicaid eligible beneficiaries except as authorized in writing by SCDHHS. **MHNs** can conduct marketing/enrollment activities at DSS and WIC county offices with DSS county Director's approval and WIC Director's approval.

The **MHN** may not make any claims or imply in any way that a Medicaid beneficiary/recipient will lose his/her benefits under the Medicaid program or any other health or welfare benefits to which he/she is legally entitled, if he/she does not enroll with the **MHN**.

**MHNs** cannot make offers of material or financial gain to potential/existing Medicaid beneficiaries to facilitate or encourage enrollment of Medicaid beneficiaries. Some examples are:

- Over the counter drug vouchers;
- Accidental death or dismemberment, disability, or life insurance policies;
- Grocery store gift certificates.

The **MHN** may not enlist the assistance of any employee, officer, elected official or agent of the state to assist in the enrollment process of Medicaid applicants/beneficiaries except as authorized in writing by the SCDHHS.

Any claims stating that the **MHN** is recommended or endorsed by any state or county agency, or by any other organization must be prior approved by SCDHHS and must be certified in writing by the State or county agency or other organization that is recommending or endorsing the **MHN**.

The **MHN** may not use any state facility in marketing and enrollment activities for Medicaid beneficiary beneficiaries, except as authorized in writing by the SCDHHS.

The **MHN** may not misrepresent or use fraudulent, misleading information about the Medicaid program, SCDHHS or its policies or any other governmental programs.

### **Medicaid Applicant/Beneficiary Contact**

The **MHN** may contact beneficiaries who are listed on their monthly member listing to assist with Medicaid re-certification/eligibility.

The **MHN** may conduct an initial follow up for all voluntary disenrollees listed on their monthly member listing. The **MHN** cannot make repeated follow up calls unless specifically requested by the Medicaid beneficiary.

### **Materials/Media/Mailings**

The materials/media should include the Medicaid **Managed Care Enrollment Help Line toll free number (1-888-549-0820)** and the **MHN's** toll free number.

The materials/media must include a statement that enrollment is voluntary.

**MHNs** can develop and **passively** distribute marketing and educational materials that have been approved by SCDHHS to potential and existing Medicaid beneficiaries at any sites approved by SCDHHS (i.e. schools, churches, community centers, provider offices, governmental offices excluding DSS). This excludes the distribution of the enrollment form.

With prior written approval by SCDHHS, that is site specific, approved **MHN** videos can be shown in doctor's waiting rooms or other approved marketing/enrollment events.

**MHNs** can, **with SCDHHS written prior approval**, utilize mass media which includes, but is not limited to, public service announcements such as radio and television spots (air time paid for by **MHN**), advertising in newspapers, magazines, church bulletins, billboards and buses.

With prior written approval of SCDHHS, that is site specific, **MHNs** can develop and use interactive media that provides information on the **MHN** program that could be accessed by persons waiting in facilities frequented by the Medicaid populations.

**MHNs** may mail SCDHHS approved marketing and educational materials within its approved service areas. Mass mailings directed to only Medicaid beneficiaries are prohibited.

**MHNs** Medicaid enrolled network providers can use SCDHHS' approved letters to inform beneficiaries about their participation status in the Medicaid Program and the **MHN**. These letters regarding providers' participation status in the Medicaid **Medical Homes** Program may not contain marketing materials or enrollment forms and must be mailed and/or distributed directly by the network provider's office.

Materials designed for the physicians participating in each **MHN** do not have to be approved by SCDHHS. However, these materials must be submitted to SCDHHS prior to distribution and are subject to review. All materials must be in compliance with the contract and the **MHN** Policy and Procedure Guide. SCDHHS reserves the right to require that any information that is incorrect or not in compliance with SCDHHS policy be corrected before distribution.

### **Enrollment Form**

**All enrollment activities currently performed by an MHN in a region of the state shall cease upon the expansion of the enrollment broker into that region. All regions are projected to be served by the enrollment broker by May 1, 2008. In all enrollment broker regions, any permission or assignment of enrollment duties or activities by the MHN, implicit or explicit, as contained in this Section or Policy and Procedure Guide, are terminated.**

**MHNs** may utilize the SCDHHS approved enrollment form to enroll Medicaid beneficiaries into its plan. No **passive** distribution of enrollment forms is allowed by an **MHN** or employee/agent of the **MHN**. Passive distribution is defined as the availability of the enrollment form through the **MHN** without the presence of a **MHN** representative (e.g. counter displays).

Distribution of **MHN** enrollment form is not allowed through mass media marketing or mass mailings.

A **MHN** provider or employee can assist a Medicaid beneficiary in completing the enrollment form and may submit the form on the beneficiary's behalf or the beneficiary can mail it directly to the Medicaid Department of Managed Care Enrollment. If the beneficiary mails the form directly, SCDHHS will contact the CSO regarding the beneficiary's participation in that practice. The **MHN** representative should inform the Medicaid beneficiaries that information regarding additional Medicaid options is

available by calling SCDHHS' toll free Helpline number.

The **MHN** representative is responsible for ensuring that the individual signing the enrollment form is a legally responsible adult and is authorized to make decisions regarding Medicaid enrollment for each beneficiary listed on the enrollment form.

### **Enrollment Incentives**

No offers of material or financial gain, other than core benefits expressed in the Contract, may be made to any Medicaid applicant/beneficiary as incentives to enroll or remain enrolled with the **Medical Homes** provider. The **MHN** provider can only use, in marketing materials and activities, any benefit or service that is **clearly specified** under the terms of the Contract, and available to **MHN** Program members for the full Contract period which has been approved by SCDHHS.

All incentive programs must be approved, in writing, by the SCDHHS prior to use.

No over-the-counter drug vouchers shall be offered to Medicaid **MHN** Program members.

No accidental death or dismemberment, disability, or life insurance policies shall be offered to any Medicaid applicants/beneficiaries or Medicaid **MHN** Program members.

### **Marketing Activities And Educational Materials**

Marketing for the **MHN** Contractor may include providing educational materials to enhance the ability of Medicaid applicants/beneficiaries to make an informed choice of Medicaid managed care options. Such educational material may be in different formats (brochures, pamphlets, books, videos, and interactive electronic media). The SCDHHS and/or its designee will only be responsible for distributing general marketing material developed by the **MHN** Contractor for inclusion in the SCDHHS enrollment package to be distributed to Medicaid applicants/beneficiaries. The SCDHHS at its sole discretion will determine which materials will be included.

The **MHN** Contractor shall be responsible for developing and distributing its own member specific marketing and educational materials including but not limited to, evidence of coverage, member handbook, and member education.

SCDHHS has established the following minimum requirements for the Contractor's **MHN** marketing/educational materials:

- The Contractor shall ensure that all **MHN** marketing and educational materials, brochures and presentations clearly present the core benefits and/or approved expanded benefits, as well as any limitations the Contractor may have. The Contractor shall also include a written statement to inform applicants/beneficiaries that enrollment is voluntary.

- The Contractor shall ensure that all materials are accurate, not misleading or confusing and do not make material misrepresentations.
- All materials shall be reviewed and approved for readability, content, reading level and clarity by SCDHHS or its designee.
- The Contractor shall ensure that all written material will be written at a grade level no higher than the fourth (4) grade or as determined appropriate by SCDHHS.
- The Contractor shall ensure that appropriate, certified foreign language versions of all marketing and educational materials are developed and available to Medicaid applicants/beneficiaries. The foreign language materials must also be approved, in writing, by SCDHHS. Foreign language versions of materials are required if the population speaking a particular foreign (non-English) language in a county is greater than ten (10) percent. (South Carolina has no such counties at this time.) If counties are later identified, SCDHHS will notify the Contractor. The Contractor is responsible for all costs associated with translation and certification. Affidavits of accuracy and reading level compliance must be submitted by the professional translation service and accompany all foreign language translations.
- **The Contractor is required to provide all materials designed for beneficiaries in Spanish.**
- When the Contractor identifies Medicaid members who have visual and/or hearing impairments, an interpreter must be made available for the South Carolina Medicaid MHN Program member(s).
- The Contractor's written material shall include its network provider list, which includes names, area of specialty, address, and telephone number(s) of all of the participating primary care providers and facilities. It shall also include a map or description of the Contractor's service area and information on the participating specialty providers, medical facilities (e.g. hospitals, labs.)
- The Contractor shall provide an explanation of any ancillary providers the Contractor may use, (e.g. Physician Assistants or Nurse Practitioners in providing its' health care services).
- The Contractor's written material must include a definition of the plan's term of "medical emergency" and "urgent emergency care" and the procedures on how to obtain such care within and outside of the Contractor's service area.
- The Contractor must provide a description of its family planning services and services for communicable diseases such as TB, STD, and HIV. This document

must contain a statement of the member's right to obtain family planning services from the plan or from any approved Medicaid enrolled provider. This document must contain a statement of the member's right to obtain TB, STD, and HIV services from any state public health agency.

- The Contractor's written materials must include procedures for making appointments for medical care including appointments with a specialist, how to obtain medical advice and how to access the Contractor's member/patient services.
- The Contractor's written materials must provide the following information on the responsibilities and rights of a **MHN** program member and an explanation of its confidentiality of medical records:
  - ✓ An explanation of member's grievance(s), appeals rights and advanced directive rights;
  - ✓ Provide information on member disenrollment and termination. An explanation of the **MHN** program member(s) effective date of enrollment and coverage;
  - ✓ The plan's toll-free telephone number; and
  - ✓ A statement that any brochure or mailer may contain only a brief summary of the plan and that detailed information can be found in other documents, (e.g. evidence of coverage, or obtained by contacting the plan).

### **Community Events And Forums**

**MHNs** can conduct marketing and/or enrollment activities only with prior notice to SCDHHS and with SCDHHS' written prior approval. Each specific marketing and/or enrollment event/site must be prior approved by SCDHHS. SCDHHS' approval will be specific by event/site/date. Network provider sites are an exception and do not require notice and approval by SCDHHS. **The dates, times and locations of all community events must be sent to SCDHHS ten (10) days prior to the event using a form or format approved by SCDHHS.** SCDHHS reserves the right to attend all community events.

**MHNs** may conduct marketing/enrollment activities at community events, forums and business locations including but not limited to, health fairs, health screenings, local health agencies, schools, churches, housing authority meetings, local businesses.

Focus Groups: **MHNs** may conduct focus group research for the general Medicaid population in order to determine this group's expectations and gain information on the best marketing methods. Such focus group research may be conducted in any geographic areas of the state including Department of Social Services (DSS) county

offices, with prior written approval from SCDHHS. No enrollment activities can occur at focus groups.

Show Vans: Show vans or similar vehicles can be used in various locations to distribute SCDHHS approved Medicaid managed care educational, marketing, and enrollment materials with SCDHHS written approval for each event/location.

## QUALITY ASSESSMENT AND UTILIZATION MANAGEMENT REQUIREMENTS

All MHNs that contract with SCDHHS to provide Medicaid MHN Program Services must have a Quality Assessment (QA) and Utilization Management (UM) process that meets the following standards:

1. Comply with 42 Code of Federal Regulations (CFR) 434.34 which states that the MHN must have a quality assessment system that (as required in the MHN Contract):
  - (a) Is consistent with the utilization control requirement of 42 CFR 456;
  - (b) Provides for review by appropriate health professionals of the process followed in providing health services;
  - (c) Provides for systematic data collection of performance and patient results;
  - (d) Provides for interpretation of this data to the practitioners; and
  - (e) Provides for making needed changes.
2. Maintain and operate a QA program which includes at least the following elements (as required in the MHN Contract):
  - (a) A QA plan which shall include a statement that the objective of the QA plan is to "monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care and resolve identified problems. QA effort should be health outcome oriented and rely upon data generated by the MHN as well as that developed by outside sources." This plan shall be submitted to SCDHHS annually.
  - (b) QA Staff - The QA plan developed by the MHN shall name a person be a registered nurse, who is responsible for the operation and success of the QA program. Such person shall have adequate and appropriate experience for successful QA, and shall be accountable for QAI in all of the MHNs own providers, as well as any MHNs subcontractors. The person shall spend an adequate percent of his/her time on QA activities to ensure that a successful QA program will exist. In addition, the Network Board should have substantial involvement in QI activities.
  - (c) QA Committee - The MHN's QA program shall be directed by a QA committee that includes membership from:
    - ◆ A variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.)
    - ◆ A variety of medical disciplines (e.g., medicine, surgery, radiology, etc.). The QA committee shall include OB/GYN and pediatric representation; and
    - ◆ MHN management, Advisory Boards or Board of Directors.

- (d) The QA committee shall be in an organizational location within the MHN such that it can be responsible for all aspects of the QAI program.
- (e) The QA activities of MHN providers and subcontractors, shall be integrated into the overall MHN/QA program. The MHN QA Program shall provide feedback to the providers/subcontractors regarding the integration of, operation of and corrective actions necessary in provider/subcontractor QA efforts.
- (f) The QA committee shall meet at least quarterly and produce written documentation of committee activities, and submit such documentation to the MHN Board and SCDHHS.
- (g) QA activities and results shall be reported in writing at least quarterly to the MHN Advisory Board. Such reports shall be submitted with quarterly reports to the SCDHHS and authorized agents.
- (h) The MHN shall have a written procedure for implementing the findings of QAI activities, and following up on the implementation to determine the results of QAI activities. Follow-up and results shall be documented in writing, go to the board and a copy sent to the SCDHHS.
- (i) The MHN shall make use of the SCDHHS utilization data which is supplied monthly, as part of the QA program.
- (j) Quality Assurance and Performance Improvement Program (QAPI): The Network shall have an ongoing quality assurance and performance improvement program for the services it furnishes to members. At a minimum, the Network shall:
  - Conduct performance improvement projects as described in Item I of this Section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have favorable effect on health outcomes and enrollee satisfaction.
  - Submit performance measurement data as described in Item k of this Section.
  - Have in effect mechanisms to detect both under-utilization and over-utilization of services.
  - Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
- (k) Performance Measurements: Annually the Contractor shall:
  - ◆ Measure and report to SCDHHS its performance, using standard measures required by SCDHHS.

- ◆ Submit to SCDHHS data specified by SCDHHS, that enables SCDHHS to measure the performance; or
  - ◆ Perform a combination of the activities described in Items k(1) and k(2) listed above.
- (l). Performance Improvement Projects (PIP): The Contractor shall have an ongoing program of performance improvement projects that focus on clinical and non-clinical areas, and that involve the following:
- Measurements of performance using objective quality indicators.
  - Implementation of system interventions to achieve improvement in quality.
  - Evaluation of the effectiveness of the interventions.
  - Planning and initiation of activities for increasing or sustaining improvement.
- For the current contract year, a PIP will be conducted on the HEDIS measurement of cervical cancer screening and breast cancer screening for the female population, serviced by the MHN.
- (m). The Contractor shall report the status and results of each project to SCDHHS as requested. Each performance improvement project must be completed in a reasonable time period so as to generally allow information on the success of performance improvements projects in the aggregate to produce new information on quality of care each year.
3. Submit information on quality of care studies undertaken which include care and services to be monitored in certain priority areas as designated annually by SCDHHS. Such information shall include sufficient detail on purpose, scope, methods, findings, and outcomes of such studies to enable the SCDHHS to understand the impact of the studies on the MHNs health care delivery system. (as required in the MHN Contract)

At a minimum, required quality of care studies will include measures for prenatal care, newborns, childhood immunizations, asthma, ER utilization and EPSDT examinations. Quality Measure Reports must be submitted to SCDHHS on a quarterly basis.

4. Assist the SCDHHS in its quality assurance activities.

The MHN will assist in a timely manner, SCDHHS and the External Quality Review Organization (EQRO) under contract with the SCDHHS as needed in identification of provider and beneficiary data required to carry out on-site medical chart reviews.

The MHN will arrange orientation meetings for physician office staff concerning on-site medical chart reviews and encourage attendance at these meetings by MHN and physician office staff, as needed.

The MHN will assist SCDHHS and the EQRO under contract with the SCDHHS, as needed, in securing records needed to conduct off-site medical chart reviews.

MHN will facilitate training provided by SCDHHS to its providers.

MHN will allow duly authorized agents or representatives of the State or Federal government, during normal business hours, access to MHN's premises or MHN subcontractor premises to inspect, audit, monitor or otherwise evaluate the performance of the MHNs or subcontractors contractual activities.

5. Assure that all persons, whether they be employees, agents, subcontractors or anyone acting for or on behalf of the provider, are properly licensed and/or certified under applicable state law and/or regulations and are eligible to participate in the Medicaid/Medicare program (as required in the MHN Contract).

The MHN shall have policies and procedures for approval of new providers and termination or suspension of a provider.

The MHN shall have a mechanism for reporting quality deficiencies which result in suspension or termination of a provider.

6. The MHN must have systems in place for coordination and continuation of care to ensure well managed patient care, including at a minimum: (as required in the MHN Contract)

- (a) Management and integration of health care through primary care providers.
- (b) Systems to assure referrals for medically necessary, specialty, secondary and tertiary care.
- (c) Systems to assure provision of care in emergency situations, including an education process to help assure that members know where and how to obtain medically necessary care in emergency situations.

7. The **MHN** shall have a system for maintaining medical records for all Medicaid members in the plan, as required in the MHN Contract, to ensure the medical record:

- (a) Is accurate, legible and safeguarded against loss, destruction or unauthorized use and is maintained, in an organized fashion, for all individuals evaluated or treated, and is accessible for review and audit.

The **MHN** shall maintain, or require its network providers and subcontractors to maintain, individual medical records for each Medicaid member which make readily available to SCDHHS and/or its designee and to appropriate health professionals all pertinent and sufficient information relating to the medical management of each enrolled member. Procedures shall also exist to provide

for the prompt transfer of patient care records to other in - or out-of-plan providers for the medical management of the member.

(b) Is readily available for MHN-wide QAI and CM activities and provides adequate medical and other clinical data required for QA/CM.

(c) Has adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

(d) Contains at least the following items:

- ✓ Patient's name, identification number, age, sex and places of residence and employment. Next of kin, sponsor or responsible party.
- ✓ Services provided through the MHN, date of service, service site and name of service provider.
- ✓ Medical history, diagnoses, treatment prescribed, therapy prescribed and drug administered or dispensed, commencing at least with the first patient examination made through or by the MHN.
- ✓ Referrals and results of specialist referrals.
- ✓ Documentation of emergency and/or after-hours encounters and follow-up.
- ✓ Signed and dated consent forms.
- ✓ For pediatric records (**ages 12 and under**), there must be a notation that immunizations are up-to-date.
- ✓ Documentation of advance directives, as appropriate.
- ✓ Documentation for each visit must include:
  - Date
  - Grievance or purpose of visit
  - Diagnosis or medical impression
  - Objective finding
  - Assessment of patient's findings
  - Plan of treatment, diagnostic tests, therapies and other prescribed regimens.
  - Medications prescribed
  - Health education provided
  - Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.

8. The **MHN** must report EPSDT and other preventive visit compliance rates. For purposes of reporting individuals by age group, the individual's age should be the age on the date of service.

9. The **MHN** shall have written utilization management policies and procedures that include at a minimum (as required in the MHN Contract):

- (a) Protocols for prior approval of services, access to care coordination, access to disease management, hospital discharge planning and establishing regular evening and weekend office hours within the Network.
  - (b) Processes to identify utilization problems and undertake corrective action.
  - (c) An after-hours call log to the practices and to the Help Line to track utilization and disposition.
  - (d) An emergency room log, or equivalent method, specifically to track emergency room utilization reports.
10. The **MHN** shall furnish Medicaid members with approved written information about the nature and extent of their rights and responsibilities as a member of the MHN (as required in the MHN Contract). The minimum information shall include:
- (a) Written information about their managed care plan,
  - (b) The practitioners providing their health care,
  - (c) Information about benefits and how to obtain them,
  - (d) Confidentiality of patient information,
  - (e) The right to file grievance about the MHN and/or care provided,
  - (f) Information that affects the members' enrollment into the **MHN**
11. Establish and maintain grievance and appeal procedures. The **MHN** shall (as required in the MHN Contract):
- (a) Have written policies and procedures which detail what the grievance system is and how it operates. The grievance procedures must comply with the guidelines outlined in 42CFR 438.400-438.424.
  - (b) Inform members about the existence of the grievance processes and that the member must first exhaust the Contractor's grievance process before submitting an appeal to SCDHHS.
  - (c) Attempt to resolve complaints and grievances through internal mechanisms whenever possible.
  - (d) Maintain a record keeping system for oral and written complaints, grievances and appeals and records of disposition.
  - (e) Provide to SCDHHS on a quarterly basis written summaries of the complaints, grievances and appeals which occurred during the reporting period to include:
    - Nature of complaint or grievance
    - Date of their filing
    - Current status
    - Resolutions and resulting corrective action

The **MHN** will be responsible for forwarding any adverse decisions to SCDHHS for further review/action upon request by SCDHHS or the Medicaid MHN Program member.

- (f) Notify the member who grieves, that if the member is not satisfied with the decision of the MHN, the member can make a request to the Division of Appeals and Hearings, SCDHHS for a State fair hearing. If the grievance/appeal is not resolved during the fair hearing, the Grievant/Appellant may request a reconsideration by SCDHHS, or file an appeal with the Administrative Law Judge Division. If the member is grieving a disenrollment request decision, the grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 CFR §438.56(e)(1).

12. SCDHHS is required to evaluate each **MHN's** compliance with SCDHHS program policies and procedures, identify problem areas and monitor the **MHN's** progress in this effort. At a minimum this will include, but is not limited to, the following:

- (a) SCDHHS will review and approve the **MHN's** written Quality Assurance and Improvement Plan. The **MHN** must submit any subsequent changes and/or revisions to its Quality Assurance and Improvement Plan to SCDHHS for approval on or before December 15<sup>th</sup> annually..
- (b) SCDHHS will review and approve the **MHN's** written grievance and appeal policies and procedures. The **MHN** must submit any subsequent changes and/or revisions to its Grievance and Appeal Policy and Procedures to SCDHHS for approval prior to implementation.
- (c) SCDHHS shall review quarterly quality measure reports. The reports will be submitted to SCDHHS in the format specified by SCDHHS.
- (d) SCDHHS staff will review the **MHN's** reports of complaints, grievances, appeals, and resolution.
- (e) SCDHHS staff will approve the **MHN's** Plan of Correction (PoC) and monitor the **MHN's** progress with the corrective action plan developed as a result of the annual external QA evaluation or any discrepancies found by SCDHHS that require corrective action.

13. External Quality Assurance Review. SCDHHS will provide for an independent review of services provided or arranged by the **MHN**. The review will be conducted annually by the External Quality Review Organization (EQRO) under contract with SCDHHS, as required in the MHN Contract. External quality assurance evaluation and EQRO responsibilities shall include:

- (a) Readiness Review Survey. The EQRO will conduct a readiness review of the Contractor as designated by SCDHHS. SCDHHS will convey the final report findings to the MHN with a request for a PoC, if one is warranted.

- (b) Assist the **MHN** in developing quality of care studies which meet SCDHHS quality indicators in the event they do not have sufficient resources or expertise to develop a focused quality of care study plan to conduct internal studies.
- (c) With SCDHHS staff, conduct workshop and training for **MHN** staff regarding the abstraction of data for the quality of care studies and other features of the annual QA evaluation.
- (d) SCDHHS will evaluate the **MHN's** compliance with the QA standards through an annual comprehensive QA evaluation. The annual review shall consist of:

**Quality Of Care Studies:** a review of medical records by specific criteria which are selected by a statistically valid sampling methodology. The quality of care studies will focus on important aspects of patient care in the clinical settings. SCDHHS selected quality of care studies will require qualified surveyors to:

- Collect aggregate data pertaining to the populations from which the sample medical records and administrative data will be selected. The quality of care studies will include indicators for prenatal care, newborns, childhood immunizations, asthma, ER utilization and EPSDT examinations. The EPSDT examinations must be broken down by age categories: under one year, one to five years, six to fourteen years and fifteen to twenty years.
- Abstract data from selected medical records and claims data for childhood immunizations, prenatal care, newborns, asthma, ER utilization and EPSDT examinations.

The EQRO will compare findings of quality care studies with findings of the **MHN's** internal QA programs. The EQRO will also provide analysis and comparison of findings across all **MHN's** in the program and with findings from other state and national studies performed on similar populations.

**Service Access Studies:** A review and evaluation of the **MHN's** performance of availability and accessibility. Studies will focus on:

- Emergency room service and utilization
- Appointment availability and scheduling
- Referrals
- Follow up care provided
- Timeliness of services

**Medical Record Survey:** will describe the compliance with medical record uniformity of format, legibility and documentation.

**Administrative Survey:** the **MHN** will be surveyed for administrative policies and procedures, committee structures, committee meeting minutes including governing body, executive, quality assurance and patient advisory. A review of the **MHN's** credentialing and recredentialing systems (if applicable) and professional contracts, support service contracts, personnel policies, performance evaluation examples, member education information, member grievance and appeal systems, member grievance files, and member disenrollment files.

- (g) An **MHN** summation meeting will be held to discuss the QA evaluation findings.
- (h) QA evaluation reports: the EQRO will submit an individual draft report to SCDHHS 30 calendar days following the completion of each **MHN** survey. An individual MHN final report will be issued by SCDHHS.

The results shall be available to participating health care providers, members and potential members.

Final EQR results, upon request, must be made available in alternative formats for persons with sensory impairments and must be made available through electronic as well as printed copies. The report shall include, at a minimum, the following:

- ✓ An assessment of the **MHN's** strengths and weaknesses
  - ✓ Recommendations for improving the quality of health care services furnished by the **MHN**;
  - ✓ As the state agency determines, methodologically appropriate, comparative information about all **MHNs** operating within the state; and
  - ✓ An assessment of the degree to which each **MHN** has addressed effectively the quality improvement recommendations made during the previous year.
- (i) Within 30 calendar days (or as specified by SCDHHS) of receipt of the final QA evaluation report, the MHN must submit any necessary Corrective Action Plan to SCDHHS.
  - (j) SCDHHS staff will conduct meetings with the **MHN** in order to monitor progress with the **MHN's** PoC developed as a result of the annual QA evaluation. The frequency for the meetings shall be determined by SCDHHS based on the findings of the annual QA evaluation.

- (k) If the **MHN** is accredited by an external organization (e.g., NCQA, URAC, etc.) the **MHN** shall provide SCDHHS with a copy of its accreditation review findings.

**Quality Measures**

**Prenatal Care**

Prenatal care is one of the services most frequently used by women of childbearing age. Most practitioners now emphasize that risk assessment and health promotion activities should occur early in pregnancy. Low birthweight infants (<2,500 grams) are 40 times more likely to die than infants of normal birthweights; very low birthweight infants (<1,500 grams) are 200 times more likely to die than infants of normal birthweight. In addition, these infants are more likely to experience neurodevelopmental handicaps, congenital anomalies, respiratory illness and complications acquired during neonatal intensive care. Due to the profound impact of prematurity and low birthweight

on the morbidity and mortality of affected children, monitoring prenatal care services is important.

1. The following measures shall be used:

For all Medicaid enrollees who delivered single or multiple live or stillborn fetus(es) of greater than or equal to 20-weeks gestation for the most recent 12-month reporting period:

- The timing of the enrollee’s enrollment in the health plan;
- Pregnancy outcome (i.e., fetal loss > 20 weeks or live birth); and
- Birthweight for each live birth (<500 grams; 500-1499 grams; 1500-2499 grams; or > 2500 grams).

2. Identifying criteria:

To determine the weeks gestation of the first prenatal visit, first determine the date of delivery and then using a gestational wheel, determine the weeks gestation at the time of the first visit. Calculation (Nagele’s Rule): Count back 3 months from the first day of the last menstrual period and add seven days.

**Trimester at enrollment of Medicaid pregnant women**

Weeks of Gestation	Number	Percent
<0		
1 - 12		
13 - 28		

29 - 40		
Unknown		
Total		

**Distribution of risk assessment for pregnant Medicaid members**

	Number	Percent
No Risk		
High Risk (Medically)		
Total		

**Pregnancy outcome of pregnant Medicaid members**

	Number	Percent
Fetal Loss > = 20 weeks		
Live Births		

**Distribution of birthweights in live births of pregnant Medicaid mothers and delivered at Level I, II or III hospitals (Levels as defined by state licensing).**

Birth weight	Number Delivered in Level I Hospitals	Percentage Delivered in Level I Hospitals	Number Delivered in Level II Hospitals	Percentage Delivered in Level II Hospitals	Number Delivered in Level III Hospitals	Percentage Delivered in Level III Hospitals	Number Unknown
<500 grams							
500-1499 grams							
1500-2499 grams							
>2499 grams							
Unknown							

Total							
-------	--	--	--	--	--	--	--

**Distribution of risk assessment Medicaid newborns**

	Number	Percent
No Risk		
High Risk (Medically)		
Total		

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**

The EPSDT program is a Federally mandated program that provides for comprehensive and preventive health examinations provided on a periodic basis that are aimed at identifying and correcting medical conditions in children and young people (birth through 20 years of age) before the conditions become serious and disabling.

1. The following indicator shall be used: Number of members receiving at least one initial or periodic screening service.
2. Identifying criteria: For some of these indicators, criteria are necessary to promote collection of comparable and reliable data.

Initial or periodic screening services are comprised of a package of these components: comprehensive health and developmental history; comprehensive unclothed physical exam; developmental assessment; nutritional assessment; dental assessment; vision screening; hearing screening; age appropriate immunizations; laboratory test; health education; and anticipatory guidance.

**Age Groups**

	Total	<1*	1-2	3-5	6-9	10-14	15-18	19 – 20
1. Number of beneficiaries enrolled								
2. Number of recommended screening services per age group for the year	XXXXXX	6.00	3	1	0.50	0.50	0.50	0.50
3. Number of recommended screening services per age group for the quarter (Line 2 multiplied by .25)	XXXXXX	1.5	.75	.25	0.125	.125	.125	.125
4. Expected number of screening services for the quarter (Line 1 multiplied by Line 3)								
5. Actual number of screening								

services for the quarter								
6. Goal	80%	80%	80%	80%	80%	80%	80%	80%
7. Screening Ratio (Line 5 divided by Line 4)	%	%	%	%	%	%	%	%

Note: The codes for reporting screening services for new and established patients are as follows:

- 99381 - New Patient under one year
- 99382 - New Patient (ages 1-4 years)
- 99383 - New Patient (ages 5-11 years)
- 99384 - New Patient (ages 12-17)
- 99385 - New Patient (ages 18-39 years)
- 99391 - Established patient under one year
- 99392 - Established patient (ages 1-4 years)
- 99393 - Established patient (ages 5-11 years)
- 99394 - Established patient (ages 12-17 years)
- 99395 - Established patient (ages 18-39 years)
- 99431 - Newborn care (history and examination)
- 99432 - Normal newborn care

\*Cut off is through the month of 21<sup>st</sup> birthday

There is no distinction for providers in initial and periodic screenings. Initial refers to the first screening after birth or the first screening after a child becomes a beneficiary for Medicaid. Periodic screenings are all screenings thereafter - the term comes from the reference to the periodicity schedule for Well Child Care recommended by the American Academy of Pediatric.

**HEDIS Reporting Measures**

Using the most current HEDIS specifications available issued by the NCQA (National Committee for Quality Assurance), the MCO will report the results annually to SCDHHS. SCDHHS will review annually the results with the MCOs, to determine the need for the MCO to complete a performance improvement project.

### INDEX OF REQUIRED FILES, REPORTS AND FORMS

This chart is a summary listing of 1) all reports to be submitted by MHNs to SCHHHS, 2) all files to be submitted by SCDHHS to MHNs and 3) all applicable SCDHHS forms to be used by MHNs in the conduct of business. A file is defined as a set of related records compiled in a specified format. A report is defined as a written document containing pre-defined data elements or record of information and a form is defined as a document used to collect or report information. The medium of all files and reports shall be electronic and follow the specifications noted in Section 13.40 Software Reporting Requirement of the 2008 MHN Contract **or** MMIS guidelines and requirements (as applicable).

All files/reports with a frequency of “monthly” are due no later than the 15<sup>th</sup> (fifteenth) day after the end of the reporting month. **The exception to this requirement is the Medicaid Enrollment Capacity Report, which is due by the 5<sup>th</sup> (fifth) day of the following month.** All files/reports with a quarterly frequency are due no later than the 30<sup>th</sup> (thirtieth) day after the end of the reporting quarter. All annual reports are due no later than the 90<sup>th</sup> (ninetieth) day after the end of the reporting year period.

<b>General Instructions and Information Technology Requirements</b>			
Information Technology Requirements		Page 59	
Data Transmission Requirements		Page 67	
Security Requirements For Users of SCDHHS’s Computer Systems		Page 68	

<b>MHN Reports to SCDHHS</b>	<b>Frequency</b>	<b>Format Specifications</b>	<b>Recipient</b>
Network Providers and Subcontractors Listing	Monthly	Page 70	Department of Managed Care Nurse Administrator for Quality
After-Hours Calls Log (Practices and Help Line)	Quarterly	Developed by MHN	Department of Managed

MHN Reports to SCDHHS	Frequency	Format Specifications	Recipient
		MHN	Care Nurse Administrator for Quality
New Member Contact Log	Quarterly	Developed by MHN	Department of Managed Care Nurse Administrator for Quality
Grievance Log with Summary Information	Collected Monthly and Reported Quarterly	Page 71	Department of Managed Care Nurse Administrator for Quality
Appeals Log with Summary Information	Collected Monthly and Reported Quarterly	Page 72	Department of Managed Care Nurse Administrator for Quality
Case Management Plan	Annually	Developed by MHN and SCDHHS	Department of Managed Care Nurse Administrator for Quality
Quality Assurance (QA) A. QA Plan B. QA Plan of Correction C. Quality Indicators D. HEDIS Reporting Measures	As Required As required Quarterly Annually	See Contract §11 See Contract §11 Page 50 Page 53	Department of Managed Care Nurse Administrator for Quality
Member Satisfaction Survey	Annually	Instrument and Survey Results	Department of Managed Care Nurse Administrator for Quality

<b>MHN Reports to SCDHHS</b>	<b>Frequency</b>	<b>Format Specifications</b>	<b>Recipient</b>
Medicaid Enrollment Capacity by Practice Report	Monthly by the 5 <sup>th</sup> of the following month	Page 73	Department of Managed Care Nurse Administrator for Quality
Performance Standards – PCP Compliance with After-Hours Coverage Standards	Annually	See MEDICAL HOMES NETWORK PROVIDER REQUIREMENTS section	Department of Managed Care Nurse Administrator for Quality
Performance Standards – PCP Compliance with Appointment Availability Standards	Annually	See MEDICAL HOMES NETWORK PROVIDER REQUIREMENTS section	Department of Managed Care Nurse Administrator for Quality
Performance Standards – PCP Compliance with Office Visit Times Standards	Annually	See MEDICAL HOMES NETWORK PROVIDER REQUIREMENTS section	Department of Managed Care Nurse Administrator for Quality

<b>SCDHHS Files to MHNs</b>	<b>Frequency</b>	<b>Format Specifications</b>	<b>Recipient</b>
Managed Care Member Listing Extract File (MLE)	Monthly	Page 75	MCO
Claims Record Description (Claims History File)	Monthly	Page 77	MCO

MHN Recipient Record Layout (Sure Claims File)	Monthly	Page 84	MCO
MCO/MHN Recipient Review Recertification File	Monthly	Page 89	MCO
MHN Record Description Reference File	Monthly	Page 93	MCO
<b>Files Exchanged between MHNs and SCDHHS</b>	<b>Frequency</b>	<b>Format Specifications</b>	<b>Recipient</b>
MCO/MHN/MAXIMUS Sync File Layout	At least monthly	Page 98	MCO
<b>Appendices</b>			
<b>County Listing</b>		Page 101	
<b>Provider Practice Specialty Table</b>		Page 102	
<b>Bills of Rights</b>		Page 105	
<b>MHN Standards</b>		Page 105	
<b>Forms Listing</b>			
Medical Home Enrollment Form		Page 116	
- SCDHHS Managed Care Plan Change Form (DHHS Form 280-2)		Page 117	
Medical Home Disenrollment Form		Page 118	

SCDHHS Request for Medicaid ID Number Form (SCDHHS 1716 ME)		Page 120	
WIC Referral Form		Page 121	
Medical Release Form		Page 122	
MHN Hospital Admission Agreement/Formal Arrangement		Page 123	
MHN Complaint Form		Page 124-125	

Note: The SCDHHS Nurse Administrator for Quality will distribute all reports to appropriate staff for action after they have been logged.

## GENERAL INSTRUCTIONS AND INFORMATION TECHNOLOGY REQUIREMENTS

## INFORMATION TECHNOLOGY REQUIREMENTS

### General Characteristics

The **MHN** Information Technology (IT) System must be sufficiently sophisticated enough to support the many functions of the **MHN** program. It will contain highly confidential data whose handling is subject to various laws and regulations. The data sets will tend to be large. Although the ultimate responsibility for patient care remains with the physician or other provider, loss or inaccurate data can impede the ability of the **MHN** to support the provision of optimal care by the provider.

The **MHN** IT System must meet the following general characteristics:

1. Compliance with Law and Regulations – The **MHN**'s data system must comply with all applicable laws and regulations for the handling of confidential health information. This includes the requirements of HIPAA for Protected Health Information; HIPAA requires assurance of privacy and security, and mandates the use of certain formats for data transfers, among other requirements.
2. Security – **MHN** IT systems must be secure from compromise by internal and external threats.
3. Accuracy – The data system must maintain data accurately and without corruption.
4. Stability and Reliability – The data system must be stable, not subject to sudden failures or unreliable behavior.
5. Robustness – The data system must have the capacity to handle very large data sets without suffering from undue degradation of performance.
6. Redundancy – At a minimum, the data sets must be backed up on a scheduled basis, and the backup copies stored on separate media in a separate geographic location from the main data center.

### Systems

The optimal system will provide access to data via secure direct client access and web-based access to the data. The system must be able to import, store, process and export large volumes of data in an acceptable amount of time. Response times for online query will be sub-second. Interface speeds will be in accordance with current industry standards. The system's architecture must be kept current with industry standards.

Please note that all interface layouts and EDI communications protocols will be dictated by SCDHHS. All EDI communications must be encrypted to meet or exceed HIPAA standards.

In general, **MHN** programs will require two different types of systems: **Transaction Systems**, which manage the day-to-day operations of the **MHN** program with more or less real-time interaction; and **Reporting and Analysis Systems**, which provide the

reports for monitoring and analyzing the performance of the program, recognizing trends and identifying problems and opportunities.

## Transaction Systems

Transaction systems allow quick access to needed data for support of daily tasks. **MHNs** require the following Transaction Systems:

### 1. Enrollment System

The **MHN** must be able to accurately track which beneficiaries are enrolled in the program at any given time. The Enrollment System must support storage and retrieval of at least the following information for each Member:

- ◆ Name
- ◆ Medicaid ID #
- ◆ Address
- ◆ Date Of Birth
- ◆ Primary Physician
- ◆ Enrollment Status (Enrolled, Disenrolled, etc.)
- ◆ Date of Enrollment
- ◆ Date of Disenrollment

### 2. Medical Management System

The Medical Management System must support, at a minimum, the following functions:

- ◆ Referral management

The Primary Care Case Management model embodied in the **MHN** program requires that members receive a referral from their primary physician for non-emergent care from other providers. Therefore, the **MHN** must have an information system that can record, track and verify referrals in a real time manner. The system must also support the functions of preauthorization and post-authorization in a similar way.

The Referral System must record, at a minimum:

- ✓ Name of the member being referred
- ✓ Member's Medicaid ID
- ✓ Identity of the referring doctor
- ✓ Identity of the provider being referred to
- ✓ Condition or diagnosis of the patient for which referral is sought
- ✓ Service being requested
- ✓ Time limit or number of visits authorized

- ✓ Referral or authorization identifying number

The Referral System must have functionality that immediately identifies attempted referrals that are duplicates of existing still-valid referrals, or that violate medical policy in some way (referrals to providers who are not Medicaid providers, for example).

- Care Management

Once high-risk, high-cost or vulnerable patients are identified, the **MHN** program is responsible for monitoring the care of such patients. For this, a system is required that supports ongoing care management by clinical personnel.

The Care Management System must include at least the following functions:

- Intake – the ability to enroll a new patient into the Care Management process. Information collected here must include patient demographics, diagnoses and conditions, treating physicians, medications, a current problem list, and contact information for all relevant providers and family.
- Contact Recording – the ability to record the relevant information regarding each contact with the patient, their providers or others relevant to the case. Contact recording must be made simple and fast, so that it can proceed in real time, during a telephone call, for example. Retrieval of records from prior contacts must be simple, fast and intuitive.
- Reminders – the ability to prompt the Care Manager/Care Coordinator with a pre-recorded reminder to perform a task (such as, call the patient) at some previously decided interval (such as, one week from the last contact).
- Best Practice Protocols – the ability to call up relevant clinical protocols representing best practices for the management of both common and complex diseases.

- Drug Utilization Management

The **MHN** program must support optimal regimens of medications for enrollees. Some mechanism must be provided for educating physicians as to the most clinically effective and cost effective drugs for each condition. At a minimum, the **MHN** program must provide online access for physicians to the drug education information it has developed.

- Quality Management

The **MHN** program must assure and improve the quality of care while it is working to reduce unnecessary costs. The information system must support quality management functions by:

- ✓ Tracking industry-standard quality measures, such as HEDIS;
- ✓ Tracking complaints by providers and enrollees, with recording of the process of investigating the complaint, as well as recording the result of the investigation and any corrective actions taken; and
- ✓ Tracking member satisfaction and provider satisfaction measures.

- Patient Education

The **MHN** program supports healthy behaviors by members and helps educate them on relevant aspects of their medical conditions, medications, planned tests or procedures. At a minimum, the **MHN** information system makes effective patient education materials available online for physicians and/or patients.

### 3. Provider Service System

The **MHN** program requires the recruitment and education of providers, and collaboration with and among them. The Provider Service System must include the following functions, at a minimum:

- Contact Management – storage and retrieval of provider contact information, plus tracking of all contacts with a provider in the course of recruitment, contracting, inservice training, education and problem resolution
- Practice Management Information – storage and retrieval of locations, office hours, age restrictions, etc.
- Contract Information - storage and retrieval of information on the provider's contracts with SCDHHS and with any **MHN** administrative organization
- Credentialing Information - storage and retrieval of information on provider's medical specialty, licensure, malpractice insurance, etc.

### 4. Financial System

The **MHN** program will potentially handle significant sums of Medicaid funds, in administrative fees and shared savings payments, and must possess adequate financial systems for the purposes of accounting, payments, audit and control. In addition, the **MHN** program may pay out performance bonuses to providers, and must have sufficiently powerful and flexible financial systems to calculate, pay and account for such bonuses. SCDHHS anticipates that the **MHN** program will become the claims processor for the physicians in the network: receiving claims (electronically and via hard copy), processing claims and paying claims. The

financial system must be able to expand to easily accommodate this function without causing any disruption to the participating providers.

The **MHN** Financial System must, at a minimum, include the following functions:

- ✓ Accounting
- ✓ Accounts Payable
- ✓ Accounts Receivable
- ✓ Provider accounting for calculation and payment of performance bonuses

## Reporting and Analysis Systems

**MHNs** must be able to produce a wide range of reports for both internal and external use, and be able to perform sophisticated analyses on very large sets of claims and enrollment data in order to optimally support the provision of quality, cost-effective care by contracted providers. A Reporting and Analysis System will perform these functions.

The **MHN** Reporting and Analysis System will have the following design:

- ✓ The Data Warehouse uses an industrial-strength relational database, typically based on Structured Query Language (SQL).
- ✓ The Data Warehouse has strong capabilities for data import and data export. It will likely be receiving data from multiple distinct sources, and must be able to output data into a variety of industry standard formats, to enable end-user presentation and manipulation in industry standard office productivity applications such as spreadsheets and PC databases.
- ✓ The Data Warehouse contains all of the relevant data needed for the **MHN's** reporting and analysis function, receiving data feeds from, at a minimum, Enrollment, Claims, Medical Management, and Financial Systems data. Data in the Data Warehouse should include, at a minimum:
  - Member demographics
  - Claims information, including at least:
    - a) Date of Service
    - b) Service/Medication Provided
    - c) Quantity of Service/Medication
    - d) Provider of Service
    - e) Place of Service
    - f) Diagnosis
    - g) Payment
    - h) Referring/Prescribing Provider
    - i) Referral/Authorization Code
    - j) Date Paid
    - k) Claim Identification Number

- l) Enrollment/Disenrollment Dates
- m) Primary Care Provider

- Primary Care Provider information
- Information on other providers
- Referral/Authorization data
- Case Management data
- Drug Utilization Data
- Quality Management data
- Financial data, including information on performance bonuses paid

The **MHN** Reporting and Analysis System will include strong tools for both report-generation and analysis of patterns and trends. The Reporting function must include, at a minimum:

- 1) A comprehensive set of standard reports, including, at a minimum:
  - a. Enrollment reports, including monthly reports on currently enrolled, newly enrolled and disenrolled beneficiaries
  - b. Referral/authorization reports, including monthly reports on members referred/authorized for services
  - c. Utilization reports, including monthly reports on hospital usage, Emergency Room usage and medication usage.
  - d. Case management reports, including monthly reports on members with target diagnoses, members in case management and utilization by target disease.
  - e. Quality management reports, including tracking of industry-standard measures such as HEDIS, plus member satisfaction and provider satisfaction.
  - f. Health maintenance reports, including quarterly reports on members who have not had recommended health maintenance interventions (such as Child Health Checkup, or Diabetic Eye Exam) within prescribed or recommended time frames
  - g. Provider profiling, report card, and performance bonus reports

Reports must have the ability to be run on a “to be determined” schedule.

- 2) In addition to a comprehensive set of standard reports, the data system should include strong tools for generating ad hoc reports as the need arises, including at a minimum:

- a. A user interface sufficiently straightforward that it is usable by non-technical end users;
- b. Ability to output results as tables and/or graphs of various types, as chosen by the user;
- c. Ability for the user to make comparisons, sort lists, drill down, roll up/combine and identify results that exceed or fall below some threshold;
- d. Ability to import and export data in various common formats for use in common office productivity tools such as spreadsheets and PC databases

## Data Transmission Requirements

The State Of South Carolina, Department of Health And Human Services (SCDHHS), utilizes the product Connect: Direct (C:D) to support EDI utilizing the TCP/IP protocol.

The State requires C:D FTP connections to be on a specified port. It is the responsibility of the connecting agency/entity to provide access through their firewall, on a designated port.

CDFTP+ provides a simple, reliable way to transfer files securely between a C:D server, at a central processing center, and remote sites. This is accomplished either through a graphical user interface (GUI), or through a command line interface that accepts common FTP commands and scripts.

- C:D FTP+ has checkpoint and restart capability.
- FTP+ is utilized at SCDHHS, on a mainframe, with Secure+, a data encryption product.
- Data integrity checking is utilized ensuring integrity of the transferred data and verifies that no data is lost during transmission.
- CDFTP+, the PC client software, is provided at no cost.

After the appropriate security and data sharing agreements are completed a connection with SCDHHS can be established. Technicians from both entities will be required to establish and test the C:D connection. At the time of connection the appropriate software, keys files, documentation, E-mail addresses, contact information, and file naming conventions will be exchanged, by SCDHHS and the agency/entity technicians, to ensure a secure connection is established.

## SECURITY REQUIREMENTS FOR USERS OF SCDHHS'S COMPUTER SYSTEMS

SCDHHS uses computer systems that contain sensitive information to carry out its mission. Sensitive information is any information, which the loss, misuse, or unauthorized access to, or modification of could adversely affect the national interest, or the conduct of The State of South Carolina programs, or the privacy to which individuals are entitled under the Privacy Act. To ensure the security and privacy of sensitive information in the State of South Carolina computer systems, the Computer Security Act of 1987 requires agencies to identify sensitive computer systems, conduct computer security training, and develop computer security plans. SCDHHS maintains a system of records for use in assigning, controlling, tracking, and reporting authorized access to and use of SCDHHS's computerized information and resources. SCDHHS records all access to its computer systems and conducts routine reviews for unauthorized access to and/or illegal activity.

Anyone with access to SCDHHS computer systems must abide by the following:

- Do not disclose or lend your IDENTIFICATION NUMBER AND/OR PASSWORD to someone else. They are for your use only and serve as your "electronic signature". This means that you may be held responsible for the consequences of unauthorized or illegal transactions.
- Do not browse or use SCDHHS data files for unauthorized or illegal purposes.
- Do not use SCDHHS data files for private gain or to misrepresent yourself or SCDHHS.
- Do not make any disclosure of SCDHHS data that is not specifically authorized.
- Do not duplicate SCDHHS data files, create subfiles of such records, remove or transmit data unless you have been specifically authorized to do so.
- Do not change, delete, or otherwise alter SCDHHS data files unless you have been specifically authorized to do so.
- Do not make copies of data files, with identifiable data, or data that would allow individual identities to be deduced unless you have been specifically authorized to do so.
- Do not intentionally cause corruption or disruption of SCDHHS data files.

A violation of these security requirements could result in termination of systems access privileges and/or disciplinary/adverse action up to and including removal from the State of South Carolina Service, depending upon the seriousness of the offense. In addition, State, and/or local laws may provide criminal penalties for any person illegally accessing or using a Government-owned or operated computer system illegally.

If you become aware of any violation of these security requirements or suspect that your identification number or password may have been used by someone else, immediately report that information to your component's Information Systems Security Officer.

Organization Contact Signature: \_\_\_\_\_ Date: \_\_\_\_\_

HHS Approver Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## MHN REPORTS TO SCDHHS

## NETWORK PROVIDER and SUBCONTRACTOR LISTING SPREADSHEET REQUIREMENTS

Please provide the following information regarding network providers and subcontractors:

1. Practitioner Last Name, First Name and Title - For types of service such as primary care providers and specialist, list the practitioner's name and practitioner title such as MD, NP (Nurse Practitioner), PA (Physician Assistant), etc.
2. Practice Name/Provider Name - Indicate the name of the provider. For practitioners indicate the professional association/group name, if applicable.
3. Street Address, City, State, Zip Code, Telephone Number of Practice/Provider - Self-explanatory
4. Medicaid Provider Number – Indicated the provider/practitioner's Medicaid provider number under which the provider/practitioner is enrolled. Also include the NPI, if available.
5. Specialty Code - Indicate the practitioner's specialty using the listing, located on page XXX.
6. New Patient - Indicate whether or not the provider is accepting new patients.
7. Age Restriction - Indicate any age restrictions for the provider's practice. For instance, if a physician only sees patients up to age 18, indicate < 18; if a physician only sees patients age 13 or above, indicate ≥ 13.
8. Contract Name/Number – Indicate which MCO subcontract the physician is associated with. Example: If the contract is for a group practice, all physicians within the group will have the same contract name/number.
9. Contract Begin Date – Indicate the date the contract became effective.
10. Contract Termination Date – Indicate the date the contract ended.

<sup>11</sup>County Served – Indicate which county or counties the provider serves by placing an "X" in the appropriate column. See County Listing.

**On separate tabs to the spreadsheet, please provide listings of all 1) new and 2) terminated providers for the month.**

### Grievance Log with Summary Information

For each grievance, utilize the following to report information:

Month/Year: Indicate reporting month and year.

Date Filed: Enter the exact month, day and year the grievance was received by the contractor.

Member Name and Number: Indicate the member’s name and the member’s Medicaid number. These should be listed exactly as they appear on the member listing report supplied to the Contractor by SCDHHS.

Summary of Grievance: Give a brief description of the member’s grievance. Include enough information to provide SCDHHS with an understanding of the member’s grievance.

Current Status: Indicate the current status of the grievance at the time of reporting; i.e., number of contacts with the member, what actions have been taken to resolve the matter, etc.

Resolution/Response Given: Indicate the resolution, the response given to the member and the date the resolution was achieved. Include enough information to provide SCDHHS with an understanding of how the grievance was resolved.

Resulting Corrective Action: Specify any corrective actions being taken by the MCO as a result of the grievance.

**Plan Name (Medicaid Number)  
Grievance Log  
Month/Year: \_\_\_\_\_**

Date Filed	Member Name	Member Number	Summary of Grievance	Current Status	Resolution/Response Given	Resulting Corrective Action

### Appeals Log with Summary Information

For each appeal, utilize the following to report information:

Month/Year: Indicate reporting month and year.

Date Filed: Enter the exact month, day and year the appeal was received by the contractor.

Member Name and Number: Indicate the member’s name and the member’s Medicaid number. These should be listed exactly as they appear on the member listing report supplied to the Contractor by SCDHHS.

Summary of Appeal: Give a brief description of the member’s appeal. Include enough information to provide SCDHHS with an understanding of the member’s appeal.

Current Status: Indicate the current status of the appeal at the time of reporting; i.e., number of contacts with the member, what actions have been taken to resolve the matter, etc.

Resolution/Response Given: Indicate the resolution, the response given to the member and the date the resolution was achieved. Include enough information to provide SCDHHS with an understanding of how the appeal was resolved.

Resulting Corrective Action: Specify any corrective actions being taken by the MCO as a result of the appeal.

**Plan Name (Medicaid Number)  
Appeals Log  
Month/Year: \_\_\_\_\_**

Date Filed	Member Name	Member Number	Summary of Appeal	Current Status	Resolution/Response Given	Resulting Corrective Action

### Medicaid Enrollment Capacity by Practice Report

Reporting Month/Year: Specify reporting month and year.

Practice Name: Specify each practice contracted with plan and indicate the county in which the practice operates.

Total Primary Care Providers: Specify the number of Full Time Equivalent (FTE) Primary Care Providers (PCPs) in each practice. An FTE is equal to one (1) PCP whose time is allocated 100% to one (1) practice. If a PCP serves more than one practice, count only a portion of the PCP's time in each practice. **DO NOT USE FRACTIONS IN THE TOTAL COUNT. ALWAYS round all fractions DOWN to the next lowest whole number.**

Total Medicaid Enrollment Capacity: For each practice, specify the number of Medicaid enrollees the practice can serve. (Total FTEs x 2500 = Maximum Capacity)

Current Medicaid Enrollment: Specify, by practice, the total number of Medicaid enrollees.

*Note: This report is due to SCDHHS the fifth of each month.*

#### Plan Name (Medicaid Number)

#### Medicaid Enrollment Capacity by Practice

Reporting Month/Year: \_\_\_\_\_

Practice Name	Total Full Time Equivalent PCPs	Total Medicaid Enrollment Capacity	Current Medicaid Enrollment

**SCDHHS FILES TO MHN**

**SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAL HOMES NETWORK RECORD DESCRIPTION**

**Member Listing Extract Record**

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
1	MLE-RECORD-TYPE	1	1	1	Internally used, should always = 'C'
2	MLE-CODE	1	2	2	A – AUTO ENROLLED R - RETROACTIVE N - NEW P – PREVIOUSLY ENROLLED WITH SAME PHYSICIAN C - CONTINUING D - DISENROLLED
3	MLE-PROV-NO	6	3	8	Physician recipient is enrolled with. File 4 – Provider File, and File 8 – Provider Group Affiliation
4	MLE-PROV-NAME	26	9	34	
5	MLE-CAREOF	26	35	60	
6	MLE-STREET	26	61	86	
7	MLE-CITY	20	87	106	
8	MLE-STATE	2	107	108	
9	MLE-ZIP	9	109	117	
10	MLE-RECIP-NO	10	118	127	Recipient identifying Medicaid number.
11	MLE-RECIP-LAST-NAME	17	128	144	Recipient identifying name/address
12	MLE-RECIP-FIRST-NAME	14	145	158	
13	MLE-RECIP-MI	1	159	159	
14	MLE-ADDR-CARE-OF	25	160	184	
15	MLE-ADDR-STREET	25	185	209	
16	MLE-ADDR-CITY & STATE	25	210	234	
17	MLE-ADDR-ZIP	9	235	243	
18	MLE-ADDR-PHONE	7	244	250	
19	MLE-COUNTY	2	251	252	
20	MLE-RECIP-AGE	3	253	255	
21	MLE-RECIP-SEX	1	256	256	M - MALE F - FEMALE U - UNKNOWN
22	MLE-RECIP-PAY-CAT	2	257	258	Recipient category of eligibility: Table 01 – Assist Pay
23	MLE-RECIP-DOB.	8	259	266	CCYYMMDD
24	MLE-ENROLL-DATE	6	267	272	YYMMDD – could be spaces for disenrolled
25	MLE-DISENROLL-DATE	6	273	278	YYMMDD – spaces if still enrolled
26	MLE-DISENROLL-REASON	2	279	280	01 - NO LONGER IN HMO PROGRAM 02 - TRANSFERRED TO ANOTHER MANAGED CARE PROVIDER 03 - MEDICAID ELIGIBILITY TERMINATED 04 - HAS MEDICARE OR IS >= 65 YEARS OF

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description
					AGE 05 - CHANGE TO NON MEDICAID PAYMENT CATEGORY 06 - MANAGED CARE PROVIDER TERMINATED 07 - OCWI (PEP AND PAYMENT CATEGORY 87) 08 - RECIPIENT HAS TPL HMO POLICY Will be spaces for enrolled recipients.
27	MLE-PREMIUM-RATE	9	281	289	Amount of Premium paid Will be zeroes for disenrolled recipients
28	MLE-PREM-DATE.	6	290	295	CCYYMM – Month for which the premium is paid. Could be spaces for disenrolled recipients.
29	MLE-REVIEW-DATE	8	296	303	CCYYMMDD – Date recipient will be reviewed for eligibility and/or managed care enrollment. Could be spaces for disenrolled recipients
30	FILLER (reserved for future use)	1	304	304	
31	MLE-SSN	9	305	313	Member's social security number
32	MLE-BOARD-NUMBER	6	314	319	Medical Home Board number
33	MLE-RECIP-AREA-CODE	3	320	322	Recipients Area Code
34	MLE-FAMILY-NO	8	323	330	Family # for recipient.
34	FILLER (reserved for future use)	10	331	340	Filler, reserved for future use

**SOUTH CAROLINA**  
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CLAIMS RECORD DESCRIPTION**  
**Medical Home Network or Managed Care Organization**

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	Recipient ID	10	1	10	C	
2.	Filler	1	11	11		
3.	Claim-Indicator	1	12	12		'M' – Verified MHN claim – Recipient is member of a MHN on date of service on the claim. This will be the only indicator found in the sure MHN monthly files. Is not valid for MCO files, or history files 'H' – Verified MCO claim – Recipient is a member of a MCO on the date of service on the claim. Is not valid for MHN files, or history files. 'S' - History Claim – Recipient was a current member of the MCO or MHN at run time. Their claims are provided for information.
4.	Filler	1	13	13	C	
5.	Recipient Pay Category	2	14	15	C	Table 01 – Assistance Pay Category – at time of claim
6.	Filler	1	16	16		
7.	Recipient RSP code1	1	17	17	C	Table 02 – RSP (Recipient Special Program) Codes
8.	Filler	1	18	18		
9.	Recipient RSP code2	1	19	19	C	Table 02 - Note: If any of the RSP fields (3-9) = '5'
10.	Filler	1	20	20		then the recipient was in a MHN
11.	Recipient RSP code3	1	21	21	C	Table 02 at the date of service of this claim.
12.	Filler	1	22	22		
13.	Recipient RSP code4	1	23	23	C	Table 02
14.	Filler	1	24	24		
15.	Recipient RSP code5	1	25	25	C	Table 02
16.	Filler	1	26	26		
17.	Recipient RSP code6	1	27	27	C	Table 02
18.	Filler	1	28	28		
19.	Recipient County	2	29	30	C	Table 03 - County Codes - residence county at time of claim
20.	Filler	1	31	31		
21.	Recipient Qualifying Category	2	32	33	C	Table 04 - Qualifying Category – at time of claim
22.	Filler	1	34	34		
23.	Recipient Date of Birth	6	35	40	C	YYMMDD
24.	Filler	1	41	41		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
25.	Recipient Sex	1	42	42	C	Table 12 – Gender
26.	Filler	1	43	43		
27.	Claim Control #	16	44	59	C	
28.	Filler	1	60	60		
29.	Claim Type	1	61	61	C	see table 5 – Claim Type
30.	Filler	1	62	62		
31.	Type of Bill	1	63	63	C	M=Medicaid, X=Crossover
32.	Filler	1	64	64		
33.	From Date of Service	6	65	70	C	YYMMDD Claim Type Z: Admit Date Claim Type J: Premium Date Claim Type G: First DOS = From All others: Date of Service= FROM
34.	Filler	1	71	71		
35.	To Date of Service	6	72	77	C	YYMMDD Claim Type Z: Discharge Date = TO Claim Type J: Effective Date of any change Claim Type G: First DOS = TO All others: Date of Service=TO
36.	Filler	1	78	78		
37.	Date Paid	6	79	84	C	YYMMDD
38.	Filler	1	85	85		
39.	Paid Amount	10	86	95	N	9999999.99 Claim Type D,Z,J,G: Total Paid – Claim All others: Total Paid – Line
40.	Filler	1	96	96		
41.	Charged Amount	10	97	106	N	9999999.99 Claim Type D,Z,J,G: Total Charged – Claim All others: Total Charged for Line
42.	Filler	1	107	107		
43.	Amt received - other (TPL)	10	108	117	N	9999999.99 Claim Type G (Nursing Home): Patient income applied to bill. All others claim types – Any other amt received. CLAIM Level field, not line i.e. for HIC & De per claim
44.	Filler	1	118	118		
45.	Clm Copayment Amount	8	119	126	N	99999.99 A(HIC), (B)Dental - Line Level D(Drug), (Z) UB92 - Claim Level
46.	Filler	1	127	127		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
47.	Line number	2	128	129	C	A (HIC) B (Dental) - Line number D - Medically necessary (field 1) Values: Y=YES, N or Blank or zero = NO All others: not used, will be 01
48.	Filler	1	130	130		
49.	Payment Message Indicator	1	131	131	C	Table 16 – Payment Messages HIC – Payment Message indicator (determines how surgical claim is paid. DRUG – Brand name medically necessary code DENTAL – Oral surgery indicator UB92 - Reimbursement Type
50.	Filler	1	132	132		
51.	Service Code	11	133	143	C	A (HIC), B(DENTAL) – Procedure Subfile & Code (first 6 bytes) Subfile = Table 6, Procedure Code – File 1 D (DRUG) - NDC code (all 11 bytes) - File 6 – NDC Drug Code Z (UB92) – attending MD UPIN if present
52.	Filler	1	144	144		
53.	Proc code modifier	3	145	147	C	A (HIC), B (DENT) – Procedure Code Modifier -Table 7 Z (UB92) - Type of Bill - Table7Z
54.	Filler	1	148	148		
55.	Place of service	2	149	150	C	A (HIC) - 2 byte place of service Table 8 B (DENT) - 1 byte place of service Table 8 Z (UB92) - Patient Status Table 8Z All others – not used
56.	Filler	1	151	151		
57.	Units	4	152	155	N	A (HIC), B (DENT) - units D (DRUG) – Quantity Z (UB92) - Inpatient - Covered Days G (NH) - Total days All Others – not used
58.	Filler	1	156	156		
59.	Diagnosis code Primary	6	157	162	C	A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes D (DRUG) - Therapeutic Class if present – Table 19
60.	Filler	1	163	163		
61.	Diagnosis code Second	6	164	169	C	A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes D (DRUG) – Generic Class if present
62.	Filler	1	170	170		
63.	Diagnosis code Admit	6	171	176	C	Z (UB92) only - Admit diagnosis: File #2 – Diagnosis Codes

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
64.	Filler	1	177	177		
65.	Funding code-1	2	178	179	C	File # 3 Fund Codes – valid for all claim types
66.	Filler	1	180	180		
67.	Funding code-2	2	181	182	C	File # 3 Fund Codes - valid only for hospital claims
68.	Filler	1	183	183		
69.	Funding code-3	2	184	185	C	File # 3 Fund Codes - valid only for hospital claims
70.	Filler	1	186	186		
71.	Paid Provider #	6	187	192	C	Provider Paid for the Services File # 4 and # 8 – Provider and Provider Group Affiliations
72.	Filler	1	193	193		
73.	Paid Provider Type	2	194	195	C	Table # 9 – Provider Types
74.	Filler	1	196	196		
75.	Paid Provider Specialty	2	197	198	C	Table # 10 – Provider Specialty
76.	Filler	1	199	199		
77.	Servicing Provider #	6	200	205		A (HIC) and B (DENT) – Provider of services All others – same as Paid Provider File # 4 and # 8 – Provider and Provider Group Affiliations
78.	Filler	1	206	206		
79.	Servicing Prov Type	2	207	208	C	A (HIC) and B (DENT): Provider of services All others – same as Paid Provider Table # 9 – Provider Types
80.	Filler	1	209	209		
81.	Servicing Prov Specialty	2	210	211	C	For A (HIC) and B (DENT) – provider of services UB92, BIO – Category of Service of Paid Provider – Table 20 All others – same as Paid Provider Table # 10 – Provider Specialty
82.	Filler	1	212	212		
83.	Prescriber ID	6	213	218	C	Prescriber Medicaid # if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use.
84.	Filler	1	219	219		
85.	Prescriber ID-Type	2	220	221	C	Prescriber Provider Type if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use.
86.	Filler	1	222	222		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
87.	Prescriber ID-SSN	9	223	231		Prescriber SSN if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use Note:
88.	Filler	1	232	232	C	
89.	Prescriber ID-NAPB	7	233	239	C	Prescriber NABP if present. Note: All the prescriber fields (42-45) are unreliable. They are reserved for future use Note:
90.	Filler	1	240	240		
91.	Refill # (blank if orig)	2	241	242	C	Blank or zeroes if original RX, otherwise # refills
92.	Filler	1	243	243		
93.	Days Supply	3	244	246	N	
94.	Filler	1	247	247		
95.	DRG	3	248	250	C	File # 6 – DRG Codes
96.	Filler	1	251	251		
97.	Outpt Visit Type	1	252	252	C	E=emergency room , Table # 11 Outpatient visit codes
98.	Filler	1	253	253		
99.	ICD9 Surgical Code 1	6	254	259	C	File # 7, Surgical Codes
100.	Filler	1	260	260		
101.	ICD9 Surgical Code 2	6	261	266	C	File # 7, Surgical Codes
102.	Filler	1	267	267		
103.	ER Revenue Code	3	268	270	C	ER Revenue code. N/A unless field #49 is equal to "E" (i.e. the claim is an ER claim)
104.	Filler	1	271	271		
105.	Provider Own Reference #	15	272	286	C	A (HIC) B (DENT) G (NH) – Provider own reference D (DRUG) – Prescription number Z (UB92) – Medical Records number
106.	Filler	1	287	287		
107.	Paid Provider Ownership Code	3	288	290	C	Table #18 – Provider Ownership
108.	Filler	1	291	291		
109.	Prescriber Number	10	292	301	C	Match to file on DHHS Drug Website # assigned to a physician which is used to identify the prescriber.
110.	Filler	1	302	302		
111.	HIC- Authorization Number	8	303	310	C	Prior authorization # for Claim Type A
112.	Filler	1	311	311		
113.	Provider County	2	312	313	C	Provider county Table 3 – County codes
114.	Filler	1	314	314		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
115.	Prior Authorization Number 1	13	315	327	C	Prior Authorization # for Claim Type B
116.	Filler	1	328	328		
117.	Prior Authorization Number 2	7	329	335	C	Prior Authorization number 2
118.	Filler	1	336	336		
119.	MHN/MCO Provider number	6	337	342	C	For sure claims (PCCM indicator = M or H) this is the MHN or MCO the recipient is a member of at the date of service. For history claims (PCCM indicator = S) this is the MHN or MCO the recipient is a current member of.
120.	Filler	1	343	343		
121.	Check Number	7	344	350	C	
122.	Filler	1	351	351		
123.	Gatekeeper Physician	6	352	357	C	Valid for MHN sure claims only (PCCM indicator = M) – This is the physician number of the gatekeeper at the date of service of the claim.
124.	Filler	3	358	360		Reserved for future use

Special instruction:

All records must be fixed length:

Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with ‘implied’ decimal. ‘V’ represents the ‘implied’ position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is \$442.97. Value in the record will be 0049297. The decimal is ‘implied’ and will not be included.

C = Character – All character fields are left justified and space filled to the right  
Unless otherwise specified there will be no signed fields

**SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MHN RECIPIENT RECORD LAYOUT**

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
1.	Recipient ID	10	1	10	C	
2.	Filler	1	11	11		
3.	Recipient Select Indicator	1	12	12	C	G-in program already (RSP present), P-possible eligible
4.	Filler	1	13	13		
5.	Recipient Status at Beginning of Current Month	1	14	14	C	N = Newly eligible this month C = Continuing eligibility U = Not eligible at beginning of current month, eligible in prior month P = Possible eligible
6.	Filler	1	15	15		
7.	Date Record Created	8	16	23	C	CCYYMMDD Date this record created
8.	Filler	1	24	24		
9.	Recipient RSP indicator	1	25	25	C	Y-has a RSP record, N-no RSP record
10.	Filler	1	26	26		
11.	Race	2	27	28	C	Table 13 Recipient Race
12.	Filler	1	29	29		
13.	Assistance Pay Cat when Eligible	2	30	31	C	Table 01 Assist Pay Category (pay category at time of eligibility)
14.	Filler	1	32	32		
15.	Recipient County where eligible	2	33	34	C	Table 03 County Codes
16.	Filler	1	35	35		
17.	Recipient # eligibility occurrences	2	36	37	N	# Eligibility occurrences until eligible during reporting period.
18.	Filler	1	38	38		
19.	Current Assist Pay Category	2	39	40	C	Table 01 Assist Pay Category (current pay category)
20.	Filler	1	41	41		
21.	Recipient Qualifying Category	2	42	43	C	Table 04 Qualifying Category
22.	Filler	1	44	44		
23.	Recipient Gender	1	45	45	C	Table 12 Gender
24.	Filler	3	46	48		
25.	Recipient Living Arrangement	4	49	52	C	Table 14 Living Arrangement
26.	Filler	1	53	53		
27.	Recipient Facility Type	3	54	56	C	Table 15 Facility Type
28.	Filler	1	57	57		
29.	Address (Care of)	25	58	82	C	
30.	Filler	1	83	83		
31.	Address Line 2-Street	25	84	108	C	
32.	Filler	1	109	109		
33.	Address Line 3-City/State	25	110	134	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
34.	Filler	1	135	135		
35.	Address - Zip Code	9	136	144	C	
36.	Filler	1	145	145		
37.	Phone Area Code	3	146	148	C	
38.	Filler	1	149	149		
39.	Phone	7	150	156	C	
40.	Filler	1	157	157		
41.	Recipient Last name	17	158	174	C	
42.	Filler	1	175	175		
43.	Recipient First name	14	176	189	C	
44.	Filler	1	190	190		
45.	Recipient Middle Initial	1	191	191	C	
46.	Filler	1	192	192		
47.	Payee	25	193	217	C	Head of Household Name
48.	Filler	1	218	218		
49.	Elig Begin Date	8	219	226	C	CCYYMMDD Medicaid Eligibility Begin Date during time frame reported.
50.	Filler	1	227	227		
51.	Elig End Date	8	228	235	C	CCYYMMDD Medicaid Eligibility End Date 99999999 = no end date
52.	Filler	1	236	236		
53.	Birthdate	8	237	244	C	CCYYMMDD
54.	Filler	1	245	245		
55.	Family number	8	246	253	C	Number which ties family members together
56.	Filler	1	254	254		
57.	# of RSP Programs enrolled In	1	255	255	N	Number of special programs recipient is eligible for
58.	Filler	1	256	256		
59.	RSP Program Code 1	4	257	260	C	Table 02 RSP (Recipient Special Program ) Codes
60.	Filler	1	261	261		
61.	RSP Provider No 1	6	262	267	C	
62.	Filler	1	268	268		
63.	RSP Provider Board No 1	6	269	274	C	
64.	Filler	1	275	275		
65.	RSP Program 1- eligible date	8	276	283	C	CCYYMMDD
66.	Filler	1	284	284		
67.	RSP Program 1- ineligible date	8	285	292	C	CCYYMMDD 99999999 = no end date
68.	Filler	1	293	293		
69.	RSP Program Code 2	4	294	297	C	Table 02 RSP (Recipient Special Program ) Codes
70.	Filler	1	298	299		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
71.	RSP Provider No 2	6	299	304	C	
72.	Filler	1	305	305		
73.	RSP Provider Board No 2	6	306	311	C	
74.	Filler	1	312	312		
75.	RSP Program 2- eligible date	8	313	320	C	CCYYMMDD
76.	Filler	1	321	321		
77.	RSP Program 2- ineligible date	8	322	329	C	CCYYMMDD 99999999 = no end date
78.	Filler	1	330	330		
79.	RSP Program Code 3	4	331	334	C	Table 02 RSP (Recipient Special Program ) Codes
80.	Filler	1	335	335		
81.	RSP Provider No 3	6	336	341	C	
82.	Filler	1	342	342		
83.	RSP Provider Board No 3	6	343	348	C	
84.	Filler	1	349	349		
85.	RSP Program 3- eligible date	8	350	357	C	CCYYMMDD
86.	Filler	1	358	358		
87.	RSP Program 3- ineligible date	8	359	366	C	CCYYMMDD 99999999 = no end date
88.	Filler	1	367	367		
89.	RSP Program Code 4	4	368	371	C	Table 02 RSP (Recipient Special Program ) Codes
90.	Filler	1	372	372		
91.	RSP Provider No 4	6	373	378	C	
92.	Filler	1	379	379		
93.	RSP Provider Board No 4	6	380	385	C	
94.	Filler	1	386	386		
95.	RSP Program 4- eligible date	8	387	394	C	CCYYMMDD
96.	Filler	1	395	395		
97.	RSP Program 4- ineligible date	8	396	403	C	CCYYMMDD 99999999 = no end date
98.	Filler	1	404	404		
99.	RSP Program Code 5	4	405	408	C	Table 02 RSP (Recipient Special Program ) Codes
100.	Filler	1	409	409		
101.	RSP Provider No 5	6	410	415	C	
102.	Filler	1	416	416		
103.	RSP Provider Board No 5	6	417	422	C	
104.	Filler	1	423	423		
105.	RSP Program 5- eligible date	8	424	431	C	CCYYMMDD
106.	Filler	1	432	432		
107.	RSP Program 5- ineligible date	8	433	440	C	CCYYMMDD 99999999 = no end date

<b>Field Number</b>	<b>Field Name</b>	<b>Number of Bytes</b>	<b>Starting Location</b>	<b>Ending Location</b>	<b>N / C</b>	<b>Description/Mask</b>
108.	Filler	1	441	441		
109.	MHN Board number	6	442	447	C	Not applicable for possible recipient file. sure file.
110.	Filler	1	448	448		
111.	Medicare Eligibility Switch	1	449	449	C	M = Medicare and Medicaid Eligible (dual) X = Only Medicaid Eligible
112.	Filler	1	450	450		
113.	Language Indicator	3	451	453	C	Table 21 – Language Codes
114.	Filler	1	454	454		
115.	Race Code-834 Compliant	1	455	455	C	Table 22 – 834 Compliant Race Codes
116.	Filler	5	456	460		

Special instruction:

All records must be fixed length:

Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with ‘implied’ decimal. ‘V’ represents the ‘implied’ position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is \$442.97. Value in the record will be 0049297. The decimal is ‘implied’ and will not be included.

C = Character – All character fields are left justified and space filled to the right  
Unless otherwise specified there will be no signed fields

**SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MCO/MHN Recipient Review Recertification File**

<b>Field Number</b>	<b>Field Name</b>	<b>Number of Bytes</b>	<b>Starting Location</b>	<b>Ending Location</b>	<b>N / C</b>	<b>Description/Mask</b>
1.	REV-FAMILY –NUMBER	8	1	8	C	Recipient identifying family number.
2.	Filler	1	9	9		
3.	REV-RECIP-NO	10	10	19	C	Recipient identifying Medicaid number.
4.	Filler	1	20	20		
5.	REV-RECIP-NAME	20	21	40	C	Recipient name, Last,First, Middle Initial
6.	Filler	1	41	41		
7.	REV-ADDR-STREET	25	42	66	C	
8.	Filler	1	67	67		
9.	REV-ADDR-CITY	20	68	87	C	
10.	Filler	1	88	88		
11.	REV-ADDR-STATE	2	89	90	C	
12.	Filler	1	91	91		
13.	REV-ADDR-ZIP	5	92	96	C	
14.	Filler	1	97	97		
15.	REV-ADDR-PHONE	15	98	112	C	
16.	Filler	1	113	113		
17.	REV-REVIEW-DATE	10	114	123	N	CCYY-MM-DD
18.	Filler	1	124	124		
19.	REV-REVIEW-MAILED	10	125	134	N	CCYY-MM-DD
20.	Filler	1	135	135		
21.	REV-PROVIDER-NO	6	136	141	C	
22.	Filler	1	142	142		
23.	REV-BOARD-PROV-NO	6	143	148	C	Applicable for medical home programs only
24.	Filler	1	149	149		
25.	REV-PAYEE-NAME	25	150	174	C	Name of payee for family
26.	Filler	1	175	175		
27.	REV-PAYEE-TYPE	3	176	178	C	Payee Type: See Note 1 below.
28.	Filler	1	179	179		
29.	REV-RECIP-PAY-CAT	2	180	181	C	Pay Categories: See Note 2 below.
30.	Filler	1	182	182		
31.	COUNTY-WORKER-FIRST-NAME	17	183	199	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N / C	Description/Mask
32.	Filler	1	200	200		
33.	COUNTY-WORKER-LAST-NAME	26	201	226	C	
34.	Filler	1	227	227		
35.	COUNTY-WORKER-PHONE	10	228	237	C	
36.	Filler	1	238	238		
37.	COUNTY-WORKER-PHONE-EXTENSION	4	239	242	C	
38.	Filler	1	243	243	C	
39.	HOUSEHOLD NUMBER	9	244	252	C	Ties households together.
40.	Filler	48	253	300		

Special instruction:

All records must be fixed length:

Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left EX: 5 bytes 123 will appear as 00123

C = Character – All character fields are left justified and space filled to the right  
Unless otherwise specified there will be no signed fields

**Note 1: Payee Types for Field 27.**

SEL SELF OR AFDC PAYEE

GDN LEGAL GUARDIAN

REL OTHER RELATIVE

AGY SOCIAL AGENCY

PPP PROTECTIVE PAYEE

REP REPRESENTATIVE PAYEE

FOS INDICATES FOSTER CHILD

SPO SPOUSE

INP LEGALLY INCOMPETENT, NO REPRESENT

**Note 1: Payment Categories for Field 29.**

10 MAO (NURSING HOMES)

11 MAO (EXTENDED TRANSITIONAL)

12 OCWI (INFANTS UP TO AGE 1)

13 MAO (FOSTER CARE/SUBSIDIZED ADOPTION)

14 MAO (GENERAL HOSPITAL)

15 MAO (CLTC)

16 PASS-ALONG ELIGIBLES

17 EARLY WIDOWS/WIDOWERS

18 DISABLED WIDOWS/WIDOWERS

19 DISABLED ADULT CHILD

20 PASS ALONG CHILDREN

30 AFDC (FAMILY INDEPENDENCE)

31 TITLE IV-E FOSTER CARE

32 AGED, BLIND, DISABLED

33 ABD NURSING HOME

40 WORKING DISABLED

41 MEDICAID REINSTATEMENT

48 S2 SLMB

49 S3 SLMB

50 QUALIFIED WORKING DISABLED (QWDI)

51 TITLE IV-E ADOPTION ASSISTANCE

52 SLMB (SPF LOW INC MEDCARE BENEFICIAR)

53 NOT CURRENTLY BEING USED

54 SSI NURSING HOMES

55 FAMILY PLANNING

- 56 COSY/ISCEDC
- 57 KATIE BECKETT CHILDREN - TEFRA
- 58 FI-MAO (TEMP ASSIST FOR NEEDY)
- 59 LOW INCOME FAMILIES
- 60 REGULAR FOSTER CARE
- 68 FI-MAO WORK SUPPLEMENTATION
- 70 REFUGEE ENTRANT
- 71 BREAST AND CERVICAL CANCER
- 80 SSI
- 81 SSI WITH ESSENTIAL SPOUSE
- 85 OPTIONAL SUPPLMENT
- 86 SUPPLEMENT & SSI
- 87 OCWI (PREGNANT)
- 88 OCWI (CHILD UP TO 19)
- 90 MEDICARE BENE(QMB)
- 91 RIBICOFF CHILDREN
- 92 ELIGIBLE FOR GAPS; NOT MEDICAID ELIGIBLE

**SOUTH CAROLINA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAL HOMES NETWORK  
RECORD DESCRIPTION  
REFERENCE FILES**

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description/File Name
	<b>FILE 1 Procedure Code File</b>				
1	PROCEDURE CODE SUBFILE	1	1	1	<b>MHN0225.FILE1.PROCEDUR.CODE</b>
2	PROCEDURE CODE	5	2	6	See Table 6, Procedure Code Subfile
3	CODE DESCRIPTION	40	7	46	
4	EFFECTIVE DATE	8	47	54	CCYYMMDD
5	FILLER (reserved for future use)	6	55	60	
	<b>FILE 2 Diagnosis Code File</b>				
1	DIAGNOSIS CODE	6	1	6	<b>MHN0225.FILE2.DIAGNOS.CODE</b>
2	CODE DESCRIPTION	40	7	46	
3	DIAGNOSIS CODE CLASS	1	47	47	A CANCER B ACCIDENT C PSYCHIATRIC D COMPLICATED PREGNANCY E NON-COMPLIC PREGNANCY F SPEECH 0 NON-COVERED 1 NO CLASSIFICATION 2 CODE EXPANDED
4	FILLER (reserved for future use)	3	48	50	
	<b>FILE 3 Fund Code File</b>				
1	FUND CODE	2	1	2	<b>MHN0225.FILE3.FUNDCODE</b>
2	CODE DESCRIPTION	23	3	25	
3	FILLER (reserved for future use)	5	26	30	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description/File Name
	<b>FILE 4 Provider File</b>				These will all be in the common Connect Direct Library <b>MHN0225.FILE4.PROVIDER</b>
1	PROVIDER NUMBER	6	1	6	MEDICAID PROVIDER NUMBER
2	PROVIDER NAME	26	7	32	
3	STREET	26	33	58	
4	CITY	20	59	78	
5	STATE	2	79	80	
6	ZIP	9	81	89	
10	TELEPHONE	10	90	99	
11	FEIN OR SSN NUMBER	9	100	108	
12	PROVIDER TYPE	2	109	110	See table 9, Provider type
13	PROVIDER STATUS	1	111	111	1 ACTIVE ELIGIBLE 2 ACTIVE PRIOR AUTHORIZATION 3 TERMINATED-INVOLUNTARY 4 TERMINATED-VOLUNTARY 5 SUSPENDED-INVOLUNTARY 7 ACTIVE, DO NOT PAY MEDICARE 8 ACTIVE PRIOR AUTHORIZATION, DO NOT PAY MEDICARE 9 ACTIVE, MEDICARE ONLY, DO NOT PAY MEDICAID
14	STATUS DATE	6	112	117	YYMMDD
15	SPECIALTY	2	118	119	See table 10, Provider specialty
16	COUNTY	2	120	121	See table 3, County codes and names
17	SORT	16	122	137	Sort key, generally last name, first name or Business name
18	NPI	10	138	147	Available if present.
19	Filler	3	148	150	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description/File Name These will all be in the common Connect Direct Library
<b>FILE 5</b>					
<b>NDC Drug Code File</b>					
1	NDC CODE	11	1	11	<b>MHN0225.FILE5.NDC.DRUGCODE</b>
2	CODE DESCRIPTION	40	12	51	
3	DRUG CLASS	1	52	52	
					1 LEGEND 2 LEGEND MULT SRCE 3 OVER-THE-COUNTER 4 OTC MULT SOURCE 5 FED MAC LEG-MS 6 STATE MAC LEG-MS 7 DESI/IRS/LTE
4	THERAPEUTIC CLASS	6	53	58	See Table 19 Drug Therapeutic Class
5	GENERIC CLASS	5	59	63	Table not available, see NDC website
3	FILLER (reserved for future use)	7	64	70	
<b>FILE 6</b>					
<b>DRG Code File</b>					
1	DRG CODE	3	1	3	<b>MHN0225.FILE6.DRUGCODE</b>
2	CODE DESCRIPTION	40	4	43	
3	FILLER (reserved for future use)	7	44	50	
<b>FILE 7</b>					
<b>Surgical Code File</b>					
1	SURGICAL CODE	6	1	6	<b>MHN0225.FILE7.SURGCODE</b>
2	CODE DESCRIPTION	40	7	46	
4	FILLER (reserved for future use)	4	47	50	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	Description/File Name These will all be in the common Connect Direct Library
	<b>FILE 8 PROVIDER MEMBERSHIP FILE</b>				<b>MHN0225.FILE8.PROVIDER.MEMBER</b>
1	PROVIDER NUMBER	6	1	6	
2	PROVIDER NAME	26	7	32	
3	GROUP PROVIDER NUMBER	6	33	38	
4	GROUP PROVIDER NAME	26	39	64	
5	NATIONAL PROVIDER NUMBER	10	65	75	
6	NATIONAL GROUP PROVIDER #	10	75	85	
7	FILLER	5	85	90	

## Files Exchanged between MHNs and SCDHHS

**MCO/MHN/MAXIMUS Sync File Layout**

<b>Field Number</b>	<b>Field Name</b>	<b>Number of Bytes</b>	<b>Starting Location</b>	<b>Ending Location</b>	<b>N / C</b>	<b>Description/Mask</b>
1.	Recipient ID	10	1	10	C	
2.	MCO or MHN Provider Number	06	11	16	C	
3.	Enroll Date	08	17	24	C	Mask - CCYYMMDD
4.	Termination Date	08	25	32	C	Mask – CCYYMMDD Blank or all 9's = open eligibility
5.	PCP Provider Number	6	33	38	C	Valid only for MHN's – preferred physician
6.	Filler	2	39	40	C	
7.	County	2	41	42	C	
8.	Recipient Last Name	17	43	59	C	
9.	Recipient First Name	14	60	73	C	
10.	Middle Initial	1	74	74	C	
11.	Filler	6	75	80		
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						

Special instruction:

All records must be fixed length:

Column N/C; N = Numeric – All numeric fields are right justified and zero filled to left

EX: 5 bytes 123 will appear as 00123

Mask will be shown as 99999V99 for fields with ‘implied’ decimal. ‘V’ represents the ‘implied’ position of the decimal.

EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is \$442.97. Value in the record will be 0049297. The decimal is ‘implied’ and will not be included.

C = Character – All character fields are left justified and space filled to the right  
Unless otherwise specified there will be no signed fields

## APPENDICES

**COUNTY LISTING**

- 01 ABBEVILLE
- 02 AIKEN
- 03 ALLENDALE
- 04 ANDERSON
- 05 BAMBERG
- 06 BARNWELL
- 07 BEAUFORT
- 08 BERKELEY
- 09 CALHOUN
- 10 CHARLESTON
- 11 CHEROKEE
- 12 CHESTER
- 13 CHESTERFIELD
- 14 CLARENDON
- 15 COLLETON
- 16 DARLINGTON
- 17 DILLON
- 18 DORCHESTER
- 19 EDGEFIELD
- 20 FAIRFIELD
- 21 FLORENCE
- 22 GEORGETOWN
- 23 GREENVILLE
- 24 GREENWOOD
- 25 HAMPTON
- 26 HORRY
- 27 JASPER
- 28 KERSHAW
- 29 LANCASTER
- 30 LAURENS
- 31 LEE
- 32 LEXINGTON
- 33 MCCORMICK
- 34 MARION
- 35 MARLBORO
- 36 NEWBERRY
- 37 OCONEE
- 38 ORANGEBURG
- 39 PICKENS
- 40 RICHLAND
- 41 SALUDA
- 42 SPARTANBURG
- 43 SUMTER
- 44 UNION
- 45 WILLIAMSBURG
- 46 YORK

**PROVIDER PRACTICE SPECIALTY TABLE**

<b><u>CODE</u></b>	<b><u>DESCRIPTION</u></b>
00	NO SPECIFIC MEDICAL SPECIALTY
01	THERAPIST, MULTIPLE SPECIALTY GROUP
02	ALLERGY AND IMMUNOLOGY
03	ANESTHESIOLOGY
04	AUDIOLOGY
05	CARDIOVASCULAR DISEASES
06	MIDWIFE
09	DERMATOLOGY
10	EMERGENCY MEDICINE
11	ENDOCRINOLOGY AND METAB.
12	FAMILY PRACTICE
13	GASTROENTEROLOGY
14	GENERAL PRACTICE
15	GERIATRICS
16	GYNECOLOGY
17	HEMATOLOGY
18	INFECTIOUS DISEASES
19	INTERNAL MEDICINE
20	PRIVATE MENTAL HEALTH
21	NEPHROLOGY/ESRD
22	NEUROLOGY
23	NEUROPATHOLOGY
24	NUCLEAR MEDICINE
25	CERTIFIED REGISTERED NURSE ANESTHETIST/ANESTHETIST ASSISTANT (CRNA/AA)
26	OBSTETRICS
27	OBSTETRICS AND GYNECOLOGY
28	SOUTH CAROLINA DEPT. OF MENTAL HEALTH
29	OCCUPATIONAL MEDICINE
30	ONCOLOGY
31	OPHTHALMOLOGY
32	OSTEOPATHY

33	OPTICIAN
34	OPTOMETRY
36	OTORHINOLARYNGOLOGY
37	HOSPITAL PATHOLOGY
38	PATHOLOGY
39	PATHOLOGY, CLINICAL
40	PEDIATRICS
41	PEDIATRICS, ALLERGY
42	PEDIATRICS, CARDIOLOGY
45	PHYSICAL MEDICINE & REHABILITATION
47	PODIATRY
48	PSYCHIATRY
49	PSYCHIATRY, CHILD
50	FEDERALLY QUALIFIED HEALTH CLINICS
51	SOUTH CAROLINA DEPT. OF HEALTH & ENVIRONMENTAL CONTROL
52	PULMONARY MEDICINE
53	NEONATOLOGY
54	RADIOLOGY
55	RADIOLOGY, DIAGNOSTIC
56	RADIOLOGY, THERAPEUTIC
57	RHEUMATOLOGY
58	FEDERALLY FUNDED HEALTH CLINICS (FFHC)
61	SURGERY, CARDIOVASCULAR
62	SURGERY, COLON AND RECTAL
63	SURGERY, GENERAL
65	SURGERY, NEUROLOGICAL
66	SURGERY, ORAL
67	SURGERY, ORTHOPEDIC
68	SURGERY, PEDIATRIC
69	SURGERY, PLASTIC
70	SURGERY, THORACIC
71	SURGERY, UROLOGICAL
78	MULTIPLE SPECIALTY GROUP
79	PHYSICIAN ASSISTANT
82	PSYCHOLOGIST
83	SOCIAL WORKER

- 84 SPEECH THERAPIST
- 85 PHYSICAL/OCCUPATIONAL THERAPIST
- 86 NURSE PRACTITIONER
- 87 OCCUPATIONAL THERAPIST
- 89 COMPREHENSIVE OUTPATIENT REHABILITATION  
FACILITY (CORF)
- 90 ALCOHOL & SUBSTANCE ABUSE
- 93 AMBULATORY SURGERY
- 95 DEVELOPMENTAL REHABILITATION, INFUSION CENTER
- 97 RURAL HEALTH CLINICS (RHC)
- 98 PRIVATE DUTY NURSING
- 99 PEDIATRIC NURSE PRACTITIONER  
AA PEDIATRIC SUB-SPECIALIST

## **BILLS OF RIGHTS**

## MEMBERS' AND POTENTIAL MEMBERS' BILL OF RIGHTS

Each Member is guaranteed the following rights:

- To be treated with respect and with due consideration for his/her dignity and privacy.
- To participate in decisions regarding his/her health care, including the right to refuse treatment.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the Federal regulations on the use of restraints and seclusion.
- To be able to request and receive a copy of his/her medical records and request that they be amended or corrected.
- To receive health care services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness or medical condition.
- To receive all information—enrollment notices, informational materials, instructional materials, available treatment options and alternatives, etc.—in a manner and format that may be easily understood.
- To receive assistance from both SCDHHS and the Contractor in understanding the requirements and benefits of the MHN plan.
- To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
- To be notified that oral interpretation is available and how to access those services.
- As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and the Contractor's responsibilities for coordination of care in a timely manner in order to make an informed choice.
- To receive information on the Contractor's services, to include, but not limited to:
  - Benefits covered.
  - Procedures for obtaining benefits, including any authorization requirements.
  - Any cost sharing requirements.
  - Service area.
  - Names, locations, telephone numbers of any non-English language spoken by current contracted providers, including, at a minimum, primary care physicians, specialists, and hospitals.
  - Any restrictions on member's freedom of choice among network providers.
  - Providers not accepting new patients.
  - Benefits not offered by the Contractor but available to members and how to obtain those benefits, including how transportation is provided.
- To receive a complete description of disenrollment rights at least annually.
- To receive notice of any significant changes in the Benefits Package.
- To receive information on the Grievance, Appeal and Fair Hearing procedures.

- To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
  - What constitutes an emergency medical condition, emergency services and post-stabilization services.
  - That Emergency Services do not require prior authorization.
  - The process and procedures for obtaining Emergency services.
  - The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services.
  - Member's right to use any hospital or other setting for emergency care.
  - Post-stabilization care services rules as detailed in 42 CFR §422.113(c).
- To receive the Contractor's policy on referrals for specialty care and other benefits not provided by the member's PCP.
- To have his/her privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.
- To exercise these rights without adversely affecting the way the Contractor, its providers or SCDHHS treat the member.

## PROVIDERS' BILL OF RIGHTS

Each Health Care Provider who contracts with SCDHHS and with the local **Medical Homes Network** to furnish services to the members shall be assured of the following rights:

- A Health Care Professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a member who is his/her patient, for the following:
  - The member's health status, medical care or treatment options, including any alternative treatment that may be self-administered.
  - Any information the member needs in order to decide among all relevant treatment options.
  - The risks, benefits and consequences of treatment or nontreatment.
  - The member's right to participate in decisions regarding his/her health care, including the right to refuse treatment and to express preferences about future treatment decisions.
- To receive information on the Grievance, Appeal and Fair Hearing procedures.
- To have access to the Network's policies and procedures covering the authorization of services.
- To be notified of any decision by the Network to deny a service authorization request, or to authorize a service in an amount, duration or scope that is less than requested.
- To challenge, on behalf of the Medicaid members, the denial of coverage of, or payment for medical assistance.
- The Network's provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
- To be free from discrimination for the participation, reimbursement or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification

## **MEDICAL HOMES NETWORK STANDARDS**

## ENROLLMENT STANDARDS FOR MEDICAL HOMES NETWORK CARE COORDINATION SERVICE ORGANIZATIONS

SCDHHS will contract with a Care Coordination Service Organization (CSO) for the purpose of the development and maintenance of a Medical Homes Network. The Network shall be defined as the participating physician practices, any advisory boards and the CSO. The CSO shall be the designated agent for the Network. Care Coordination Service Organizations (CSO) are to be experienced, responsive, responsible and financially sound organizations that provide infrastructure and support to the Network and the participating primary care practices. If the Network/CSO so chooses, it may disburse to each participating provider a Per Member Per Month (PMPM) Care Coordination fee for each enrolled member. The PMPM will be paid by the CSO. The CSO is encouraged/will be expected to develop/design an incentive based formula for the distribution of the PMPM. The State intends to provide an incentive to the network by sharing any documented cost savings with the network through the CSO by utilizing an agreed-upon formula established by independent actuaries contracted by the State. The CSO will be responsible for dividing the Network's share between the participating practices and the CSO, based upon the agreement established between the CSO and the practices. The CSO will be responsible for components and services as follows:

- Formal Care Coordination and Case Management
- Service Utilization Management/Track services provided to members
- Member Education
- Disease Management
- Provider Education and training on evidence-based medicine and Best Practice protocols.
- Pharmacy Management to include, but not limited to: Benefit Management Oversight and Clinical Risk Identification
- Exception and performance tracking and reporting
- Outcomes measurement and data feedback.
- Distribution of any Per Member Per Month care coordination fee to the participating physicians.
- Distribution of any cost savings

The Scope of Work the CSO is expected to perform consists of these components:

1. Development, maintenance and expansion of a network of physicians that will assume the responsibility of providing medical homes for Medicaid beneficiaries in their respective service areas. The CSO is expected to provide a sufficiently developed infrastructure to support the member practices in the management of the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner. This infrastructure should include, at a minimum:
  - A protocol for care coordination/case management to include:
    - Proposed care coordination staffing.

- Proposed methodology for defining which patients will receive care coordination services. Patients who are considered “high utilizers” and/or non-compliant must be targeted for care coordination.
  - Proposed procedures to follow up with patients admitted to the hospital, seen at the emergency room or by some other medical professional.
  - Proposed procedures for addressing non-compliant members.
  - Disease Management initiatives based on the network’s demographics, including protocols for at least two (2) disease states.
  - Pharmacy Oversight and Management.
  - 24-hour call service/Help Line/Nurse Line that is staffed 24 hours per day, 7 days per week
2. Assistance to the MHN to ensure their ability to provide:
    - Care Coordination and Case Management
    - Disease Management
    - Pharmacy oversight and management
  3. Demonstrate budget neutrality or cost savings for services to beneficiaries in the plan.
  4. Management of the medical and health care needs of members to assure that all medically necessary services are made available in a timely and cost efficient/effective manner.
  5. The monitoring and follow-up on care provided by other medical service providers for diagnosis and treatment, to include externally referred services.
  6. Ensuring that the participating PCPs meet the following standards:
    - A. The practices must provide primary care and patient care coordination services to each member.
    - B. The practices must provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week.
    - C. There must be prompt (within one hour) access to a qualified medical practitioner who is able to provide medical advice, consultation and authorization for service when appropriate. PCPs must have at least one telephone line that is answered by office staff during regular office hours. (Use of an automated system to answer the phone is acceptable as long as patients are able to access a live person through one of the automated options.)
    - D. PCPs must provide members with an after-hours telephone number. The after-hours number may be the PCP’s home telephone number, an answering service, etc. The after-hours telephone number must be listed in the member’s handbook. Changes to the after hours number should be reported to the Care Coordination Services Organization.
    - E. The practices must provide preventive services as defined by the network advisory board.

- F. The practices must offer general patient education services to all members and potential members as well as disease management services to members for whom the services are appropriate.
- G. MHN PCPs must establish and maintain hospital admitting privileges or enter into an arrangement with another physician or group practice for the management of inpatient hospital admissions of MHN members.
- H. The practices will assist the member by providing systematic, coordinated care and will be responsible for all referrals for additional medically necessary care to other health care providers.
- I. The practices will be required to follow the recommended Early and Periodic Screening, Diagnosis and Treatment (EPSDT) screening schedules, as required by the Centers for Medicare and Medicaid Services (CMS).
- J. The practices will be required to utilize the following standards for Appointment Availability:
  - Emergency care – immediately upon presentation or notification
  - Urgent care – within 24 hours of presentation or notification
  - Routine sick care – within 3 days of presentation or notification
  - Routine well care – within 45 days of presentation or notification (15 days if pregnant)
- K. The practices will be required to utilize the following standards for office visit times
  - Walk-ins – within two hours or schedule an appointment within the standards of appointment availability listed above
  - Scheduled appointment – within one hour
  - Life-threatening emergency – must be managed immediately

The CSO must be an established entity with its own tax ID number. Organizations interested in participating in a MHN should call the SCDHHS Division of Care Management at 803-898-4614 to inquire about the contractual arrangements.

NOTE: An CSO that also operates a Medicaid Managed Care Organization in South Carolina will not be allowed to conduct business as both an CSO and an MCO within the same county.

### **Minimum Criteria**

A CSO/Network must meet the following criteria and be approved in order to be considered for participation in the Medical Homes Program. The identified protocols must also be submitted and approved by SCDHHS.

1. Must demonstrate experience as a Care Coordination Services Organization in a Medicaid managed care environment.
2. Demonstrated evidence of successful development of physician networks.
3. Demonstrated network and physician management to include:
  - Provider satisfaction data
  - Cost effectiveness data, and

- Quality data (member satisfaction and documented Quality Improvement Program).
4. Appropriate credentials and Medicaid-specific experience of all staff personnel (either current to be documented in resumes or to be required and documented in job descriptions) dedicated to the program.
  5. Demonstrated utilization management abilities to include:
    - Referral Management
    - Drug utilization review
    - Practice guidelines
  6. Demonstrated ability to engage the target populations (PCPs and Beneficiaries/Members) resulting in provider and member satisfaction and to facilitate increased coordinated access to care.
  7. Demonstrated ability to coordinate with and educate health care providers and to sustain participation and coordination with these providers. Submit documentation of education provided to the providers over the past 5 years. Submit evidence of provider retention over the past 5 years; provider retention must be at least 80%.
  8. Demonstrated ability to identify and address quality of care issues (e.g., identify gaps between recommended prevention and treatment and actual care provided to members).
  9. Demonstrated ability to apply nationally recognized, evidence-based clinical guidelines in the application of services.
  10. Demonstrated ability to educate MHN members and/or their caregivers regarding child development, childhood diseases and any particular health care condition and the needs brought about by health problems, with the goal of increasing MHN member and/or caregiver understanding and to enhance their effectiveness in self-care. Submit examples of education provided to the members over the past 5 years. Submit all materials used, description of activities, etc. conducted with members over the past 5 years. Include both English and Spanish versions.
  11. Demonstrated ability to manage various health and any co-morbid conditions.
  12. Demonstrated ability to assure ongoing monitoring and evaluation of MHN member health status. Submit detailed descriptions of activities implemented to address health status issues and the resulting effects in acute care costs.
  13. Demonstrated ability to assure ongoing monitoring and evaluation of MHN provider service utilization and progress on program outcomes. Submit sample reports.
  14. Demonstrated ability to manage and analyze MHN member and MHN provider demographic, utilization and cost data. Submit sample reports.
  15. Demonstrated ability to comply with current HIPAA regulations.
  16. Demonstrated financial soundness. Each Network must provide assurances that the State of South Carolina, SCDHHS or Medicaid beneficiaries will not be liable for the Network's debt if the Network becomes insolvent. The Network must provide evidence of a reserve account with a federally guaranteed financial institution. Additional Fiscal Requirements are found in the MHN Application.
  17. Must provide management team's credentials and background summaries.
  18. Demonstrated information technology proficiency to include

- Enrollment tracking
- Re-determination tracking
- Data support for utilization management and case management services
- Ownership of or a contractual relationship with a data warehouse or central database with the ability to provide monthly, yearly and ADHOC reports to the advisory board, individual physicians and SCDHHS.

See **Information Technology Requirements** beginning on page 87 for more detailed specifications on IT/data system requirements.

19. Demonstrated care management protocols to include:
  - Staffing criteria
  - Procedures for identifying patients in need of care management
  - Ability to work with families and other community supports/providers
  - Ability to engage members in care management
  - Care manager access protocols (Please describe how a member accesses the care manager; i.e., assignment, request, chronic condition, missed appointment, etc.)
  - Care management protocols for specific diseases
  - Patient education methods and capacities.
  - *NOTE: The CSO may operate its 24-hour Help Line outside of South Carolina. However, in anticipation of care coordination services that must be delivered face-to-face, the CSO will be expected to employ or contract with local Care Coordinators*
20. Demonstrated ability to begin full operation within 30 days of receiving a contract from SCDHHS.
21. None of the primary parties involved in the Network or any affiliated personnel can have any outstanding debt with SCDHHS.
22. In establishing/building its provider network, the CSO/Network must target medically underserved areas of South Carolina.
23. A CSO shall not be a subsidiary of a parent company currently engaged in a managed care contract with South Carolina Medicaid.
24. Protocols addressing the following:
  - A. A protocol to ensure regular evening and weekend office hours to accommodate the needs of the members. This must be submitted within six (6) months of the Network beginning operations.
  - B. A protocol to provide medical homes for Medicaid patients that do not have a medical home and/or use the Emergency Room as their PCP.
  - C. A protocol to educate Medicaid beneficiaries on appropriate use of the ER and other medical services and to divert members from the emergency room to urgent care or primary care when appropriate.
  - D. A protocol to control, monitor and follow-up on care provided by other medical service providers for diagnosis and treatment.
  - E. A protocol for furnishing providers and members with evidence-based information and resources to support optimal health management.
  - F. A protocol that emphasizes and defines prevention and self-care

- G. A data management, reporting and feedback process with Network members to track exceptions and performance, to improve health outcomes, document cost effectiveness, including monthly patient profile reports. SCDHHS will provide data to the Network and the providers, which detail the claims activities on all enrolled members.
- H. A protocol on maintaining Medicaid eligibility, to include providing assistance to members in completing the eligibility renewal process to reduce the percent of members whose eligibility is interrupted due to failure to respond properly during the re-determination process.
- I. A protocol to educate new and potential members on the enrollment process.
- J. A protocol to ensure the cultural competency of the Network.
- K. A protocol for involving the participating physicians in the oversight and direction of initiatives for the network to include:
  - ✓ Establishing best practices
  - ✓ Monitoring overall quality of care within the network
  - ✓ Monitoring overall network costs to Medicaid
  - ✓ Utilization of data management to improve healthcare for the state

In order to demonstrate the various skills and abilities detailed above, the interested CSO must answer a series of questions addressing the following:

1. Organizational experience
2. Provider education and interface
3. Beneficiary Help Lines which are staffed 24-hour per day/7 days per week and 24-hour/7 day access to the practice (This may be accomplished through an answering service. An answering machine that merely directs the members to the ER is not acceptable.)
4. Care Coordination system
5. Care Coordination staff
6. Provider engagement
7. Disease Management system
8. Quality Assessment and Improvement program
9. Evaluation
10. Shared savings distribution formula
11. Care Coordination Per Member Per Month distribution formula
12. References
13. Data systems
14. Protocols
15. Previous External Quality Review experience
16. Enhanced care coordination to special populations

# FORMS

<<Insert name of Network>>  
**MEDICAL HOMES ENROLLMENT FORM**

The MEDICAL HOMES PROGRAM has been explained to me and I have read and understand how the program would affect me/or my family.

I wish to enroll in the Medical Homes Program with << Insert name of PCP>>. I authorize the release of medical records to my primary care doctor, the Network Administrator and the Department of Health and Human Services.

PRINT THE NAME OF EACH FAMILY MEMBER TO BE ENROLLED (LAST, FIRST, MIDDLE INITIAL)	BIRTH DATE	MEDICAID ID NUMBER

<p>FAMILY ADDRESS</p> <p>C/O _____</p> <p>Street _____</p> <p>City _____ -State _____ Zip _____</p>	<p>PHONE NUMBER (____) _____ Area Code</p> <p>COUNTY _____</p>
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<p>By signing this, I agree to be enrolled in the Medical Homes program with my doctor, &lt;&lt;Insert doc's name here&gt;&gt;. I verify that I have legal custody of any minor children listed on this Enrollment Form and have the authority to make health care decisions on their behalf.</p> <p><b>Signature:</b> _____</p>	<p><b>Date:</b> _____</p>
--	---------------------------



**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES  
MEDICAL HOMES DISENROLLMENT FORM**

The patient(s) listed below are to be disenrolled from the Medical Homes Program for the reason(s) indicated below. Please check all that apply. The patient(s) is enrolled with the following practice: \_\_\_\_\_

- Behavior by the member which is disruptive, unruly, abusive or uncooperative to the extent that our ability to provide services to the member or other affected members is seriously impaired.
- Persistent refusal of a member to follow a reasonable, prescribed course of treatment.
- Member moved/Transferred to another practice.
- Fraudulent use of the Medicaid card.

PRINT THE NAME OF EACH FAMILY MEMBER TO BE DISENROLLED (LAST, FIRST, MIDDLE INITIAL)	BIRTH DATE	MEDICAID ID NUMBER OR SOCIAL SECURITY NUMBER

FAMILY ADDRESS C/O _____ Street _____ City _____ State _____ Zip _____	PHONE NUMBER (____) _____ Area Code  COUNTY _____
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**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Practice Name: \_\_\_\_\_ Practice Number: \_\_\_\_\_

**South Carolina Department of Health and Human Services  
REQUEST FOR MEDICAID ID NUMBER**

FROM (Provider name and address):	TO: (SCDHHS Medicaid Eligibility)
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**IDENTIFYING INFORMATION FURNISHED BY MEDICAID PROVIDER**

**A. MOTHER:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Were parental rights terminated prior to delivery? \_\_\_ Yes \_\_\_ No

Did the mother have a permanent sterilization procedure? \_\_\_ Yes \_\_\_ No

Medicaid ID Number: \_\_\_\_\_ County: \_\_\_\_\_

Medicaid Eligibility Worker Name (if known): \_\_\_\_\_

**B. CHILD:**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Has application been made for a SSN for the child? \_\_\_ Yes \_\_\_ No

Provider representative furnishing information: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAID ELIGIBILITY INFORMATION FURNISHED BY SCDHHS**

(Within 5 working days)

Child's Medicaid ID Number: \_\_\_\_\_

Effective date of Eligibility: \_\_\_\_\_

Medicaid Eligibility Worker: \_\_\_\_\_ Date: \_\_\_\_\_

Location: \_\_\_\_\_ Telephone number: \_\_\_\_\_

**WIC REFERRAL FORM**

**PL103-448, §204(e) requires States using managed care arrangements to serve their Medicaid beneficiaries to coordinate their WIC and Medicaid Programs. This coordination should include the referral of potentially eligible women, infants, and children and the provision of medical information to the WIC Program. To help facilitate the information exchange process, please complete this form and send it to the address listed below. Thank you for your cooperation. .**

**Name of Person being referred:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

The following classifications describe the populations served by the WIC program. Please check the category that most appropriately describes the person being referred:

- \_\_\_\_\_ Pregnant woman
- \_\_\_\_\_ Woman who is breast feeding her infant(s) up to one year postpartum
- \_\_\_\_\_ Woman who is non-breast feeding up to six months postpartum
- \_\_\_\_\_ Infant (age 0-1)
- \_\_\_\_\_ Child under age 5

States may consider using this space to either include specific medical information or to indicate that such information can be provided if requested by the WIC Program.

**Provider's Name:** \_\_\_\_\_

**Provider's Phone:** \_\_\_\_\_

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

\_\_\_\_\_  
 (Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian)

**Send completed form to:**

WIC Program Contact  
 Address  
 Phone Number

**MEDICAL RECORD RELEASE**

I, the undersigned, give permission for my provider, acting on my behalf, to refer my name for WIC services and to release necessary medical record information to the WIC agency.

**Signature** \_\_\_\_\_  
*(signature of patient being referred or, in case of children and infants, the signature and printed name of the parent/guardian)*

**Date** \_\_\_\_\_

MHN Hospital Admission Agreement/Formal Arrangement Form

MEDICAL HOMES NETWORK

SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206, Phone (803) 898-2818

South Carolina MHN Hospital Admission Agreement/Formal Arrangement

This form is to be completed in lieu of having hospital admitting privileges.

SC MHN Primary Care Provider Applicant

(First Party Section)

Applicant Name: \_\_\_\_\_ Provider Number: \_\_\_\_\_

Group Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

To ensure a complete understanding between both parties and continuity of coverage among providers, SC MHN has adapted the SC MHN Patient Admission Agreement/Formal Arrangement Form. This form serves as a formal written agreement established between the above parties for the following:

- The SC MHN Primary Care Provider is privileged to refer adult/pediatric and Emergency patients to the second party for hospital admission. The second party is agreeing to treat and administer to the medical needs of these patients while they are hospitalized.
• The second party will arrange coverage for SC MHN member admissions during his/her vacation.
• This agreement may be terminated by either of the parties at any time by giving written 30 days advance notice to the other party or by mutual agreement.
• The SC MHN Primary Care Provider will notify SC MHN in writing of any changes/terminations to this agreement.
• The SC MHN Primary Care Provider will provide the second party with the appropriate payment authorization number.

Physician and/or Group Agreeing to Cover Hospital Admissions For Above SCMHN Provider Applicant:

(Second Party Section)

Physician/Group Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_ Phone Number: \_\_\_\_\_

Specialty: \_\_\_\_\_ Ages Admitted: \_\_\_\_\_

Hospital Affiliation(s) and Location(s): \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

<<Name of Network>> COMPLAINT FORM

\*Note: For reporting complaints regarding MHN Providers ONLY

Mail the completed, signed form to: Network Office
Street Address or PO Box
City, State, Zip code

Name of Person Completing this Form:
(may be MHN member, designated friend/family member, medical provider, hospital, community member, etc.)

Relationship to Member: Date Form Completed:

MHN Member Name: DOB:

Medicaid ID: County of Residence:

Address:

Telephone Number:

Name of Doctor:

Practice:

Please describe your complaint in detail including dates/names. Please attach any additional documentation.

Multiple horizontal lines for writing the complaint details.

Over (See Consent Statement and Signature)

continued

## SC MHN COMPLAINT FORM

(page 2)

<<Name of Network>> staff reviews all complaints that come to our office. We take each complaint seriously and have a process in place for addressing each one. It is not necessary for us to use your name when investigating a complaint. However, it is more effective to have your name when describing the concern to the provider. Therefore, we have included a place to sign your name on this form that will let us use your name when investigating your complaint.

**Please do not sign both statements.**

**1. If you agree to allow us to use your name in investigating this complaint, please sign the following:**

I give the SC MHN Managed Care staff permission to use my name when sharing my complaint with the Primary Care Provider (PCP) named in my complaint. The PCP has my permission to respond to the SCMHN staff concerning my complaint and release medical records regarding the patient when necessary.

\_\_\_\_\_  
Signature of Complainant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date of Birth

**OR**

**2. If you would like your name to remain confidential and you do not want us to use your name in the investigation of this complaint, please sign below:**

\_\_\_\_\_  
Signature of Complainant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date of Birth

If you have any questions regarding the use of this form or the MHN Complaint Process, please contact the <<Name of Network>> office at <<insert telephone number>>. *Thank you for giving us this opportunity to serve you better.*

**Please Do Not Write Below This Line**

MHN PCP Name: \_\_\_\_\_

MHN PCP#: \_\_\_\_\_

MHN Practice Name: \_\_\_\_\_

Location: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

# GLOSSARY

## GLOSSARY

The following terms, as used in this Guide, shall be construed and interpreted as follows unless the context clearly requires otherwise.

**Action** – A termination, suspension or reduction (which includes denial of a service based on Office of General Counsel interpretation of CFR 431) of Medicaid eligibility or covered services. It further means determinations by skilled nursing facilities and nursing facilities to transfer or discharge residents and adverse determinations made by a State with regard to the preadmission screening and annual resident review requirements of section 1919(e)(7) of the Act.

**AFDC/Family Independence** - Aid to Families with Dependent Children.

**Applicant** - An individual seeking Medicaid eligibility through written application.

**Beneficiary** - A person who is determined eligible in receiving services as provided for in the Title XIX SC State Medicaid Plan.

**CFR** - Code of Federal Regulations.

**CPT-4** - Current Procedural Terminology, fourth edition.

**Care Coordination** - The manner or practice of planning, directing and coordinating health care needs and services of Medicaid **MHN** Program members.

**Care Coordinator** - The individual responsible for planning, directing and coordinating services to meet identified health care needs of Medicaid **MHN** Program members.

**Care Coordination Fee** – The amount paid to the Contractor per member per month (PMPM) for each **MHN** member who has chosen the Contractor.

**Care Coordination Services Organization** – Experienced, responsive, responsible and financially sound organizations that provide infrastructure and support to the Network and the participating primary care practices.

**Case** - A household consisting of one or more Medicaid beneficiaries.

**Case Manager** - The individual responsible for identifying and coordinating services necessary to meet service needs of Medicaid **MHN** Program members.

**Certificate of Coverage** - The term that describes services and supplies provided to Medicaid **MHN** program member, which includes specific information on benefits, coverage limitations and services not covered. The term "certificate of coverage" is interchangeable with the term "evidence of coverage".

**Contractor** – The individual practice and/or the **MHN** Board that has executed a formal agreement with SCDHHS to enroll and serve Medicaid **MHN** Program members under the terms of the **MHN** contract. The term Contractor shall include all employees, subcontractors, agents, volunteers and anyone acting on behalf of, in the interest of, or for a Contractor.

**Co-payment** - Any cost-sharing payment for which the Medicaid **MHN** Program member is responsible for in accordance with 42 CFR, § 447.50.

**Core Benefits** - A schedule of health care benefits provided to Medicaid **MHN** Program members enrolled in the Contractor's plan as specified under the terms of the **MHN** contract.

**Covered Services** - Services included in the South Carolina State Medicaid Plan.

**Contractor** - The **MHN** that has executed a formal agreement with SCDHHS to enroll and serve Medicaid **MHN** Program members under the terms of the contract. The term Contractor shall include all employees, subcontractors, agents, volunteers and anyone acting on behalf of, in the interest of, or for a Contractor.

**DHEC** - Department of Health and Environmental Control.

**Disenrollment** - Action taken by SCDHHS or its designee to remove a Medicaid **MHN** Program member from the Contractor's plan following the receipt and approval of a written request for disenrollment or a determination made by SCDHHS or its designee that the member is no longer beneficiary for Medicaid or the Medicaid **MHN** Program.

**Documented Cost Savings** – Those cost savings verified by SCDHHS by using an independent actuary to establish the baseline and to conduct periodic reconciliation during the Contract period. The difference between the Medicaid Upper Payment Limit of the Medical Homes Network enrollees as defined/calculated in Appendix B of the Contract and the total amount of covered claim expenditures incurred by Medical Homes Network enrollees (including the prospective per member per month case management/care coordination fee payments) during the contract period.

**Dual-Eligibles** - Applicants that receive Medicaid and Medicare benefits.

**EPSDT** - The Early and Periodic Screening, Diagnosis and Treatment Program mandated by Title XIX of the Social Security Act.

**Eligible(s)**- A person who has been determined eligible to receive services as provided for in the Title XIX SC State Medicaid Plan.

**Emergency Medical Condition** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect

to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

**Emergency Services** – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title; and (2) needed to evaluate or stabilize an emergency medical condition.

**Enrollee** – A Medicaid beneficiary who is currently enrolled in an MCO, PIHP, PAHP, or PCCM in a given managed care program.

**Enrollment (Voluntary)** - The process in which an applicant/beneficiary selects a Contractor and goes through an educational process to become a Medicaid **MHN** Program member of the Contractor.

**Evidence of Coverage** - The term which describes services and supplies provided to Medicaid **MHN** Program members, which includes specific information on benefits, coverage limitations and services not covered. The term "evidence of coverage" is interchangeable with the term "certificate of coverage".

**FFP** - Federal Financial Participation. Any funds, either title or grant, from the Federal Government.

**FTE** - A full time equivalent position.

**Family Planning Services** - Services that include examinations and assessments, diagnostic procedures, health education and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics and pharmacies.

**Federally Qualified Health Center/FQHC** - A South Carolina licensed health center that is certified by the Centers for Medicare and Medicaid Services and receives Public Health Services grants. A FQHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A FQHC provides a wide range of primary care and enhanced services in a Medically underserved Area.

**Fee-for-Service (FFS) Medicaid Rate** - A method of making payment for health care services based on the current Medicaid fee schedule.

**Fraud** – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

**Health Care Professional** – A physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, Physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist and certified respiratory therapy technician.

**HCPCS** - CMS's Common Procedure Coding System.

**ICD-9** - International Classification of Disease, 9th revision.

**MMIS** - Medicaid Management Information System.

**Managed Care Organization** – An entity that has, or is seeking to qualify for, a comprehensive risk contract that is—(1) A Federally qualified HMO that meets the advance directive requirements of subpart I of 42CFR § 489; or (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) Makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area service by the entity; and (b) Meets the solvency standards of 42CFR §438.116. This includes any of the entity's employees, affiliated providers, agents, or contractors.

**Managed Care Plan** - The term "Managed Care Plan" is interchangeable with the terms "Contractor", "Plan", or "HMO/MCO".

**Marketing** – Any communication approved by SCDHHS, from a PCP/MHN to a Medicaid beneficiary who is not enrolled in that entity, that can be reasonably interpreted as intended to influence the beneficiary to enroll in that particular MHN Medicaid product, or either to not enroll, or to disenroll from, another MHN or MHN Medicaid product.

**Marketing Materials** – Materials that (1) are produced in any means, by or on behalf of an MHN and (2) can be reasonable interpreted as intended to market to potential members.

**Mass Media** - A method of public advertising that can create plan name recognition among a large number of Medicaid beneficiaries and can assist in educating them about potential health care choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, newsletters and video in doctor's office waiting rooms.

**Medicaid** - The medical assistance program authorized by Title XIX of the Social Security Act.

**Medicaid Provider** - An institution, facility, agency, person, corporation, partnership or association approved by SCDHHS which accepts payment in full for providing benefits, the amounts paid pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

**Medical Homes Networks (MHN)** - A group of physicians, who have agreed to serve as Primary Care Case Management (PCCM) providers, and other health care providers who partner with an Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for members and for managing members' care.

**Medical Record** - A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, including, but not limited to,

outpatient and emergency medical health care services whether provided by the Contractor, its subcontractor or any out of plan providers.

**Medically Necessary Service** - Those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap or result in illness or infirmity of a Medicaid **MHN** Program member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of Medicaid **MHN** Program a member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

**Member or Medicaid MHN Program Member** - An eligible person(s) who voluntarily enrolls with a SCDHHS approved Medicaid **MHN** Contractor.

**NDC** - National Drug Code.

**Non-Covered Services** - Services not covered under the Title XIX SC State Medicaid Plan.

**Non-Emergency** - An encounter by a Medicaid **MHN** Program member who has presentation of medical signs and symptoms, to a health care provider, and not requiring immediate medical attention.

**Non-Participating Physician** - A physician licensed to practice who has not contracted with or is not employed by the Contractor (**MHN**) to provide health care services.

**Plan** - The term "Plan" is interchangeable with the terms "Contractor," "**Medical Homes Network Program**," or "**MHN**,"

**Policies** - The general principles by which SCDHHS is guided in its management of the Title XIX program, as further defined by SCDHHS promulgations and by state federal rules and regulations.

**Post-Stabilization Services** - Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or improve or resolve the member's condition.

**Primary Care** – All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

**Primary Care Case Management** – A system under which a Primary Care Case Manager contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries.

**Primary Care Case Manager (PCCM)** – A physician, a physician group practice or an entity that employs or arranges with physicians to furnish primary care case management services to Medicaid beneficiaries.

**Primary Care Physician (PCP):** An individual physician or group medical practice who agrees to serve as the Member's primary physician, contribute to the development and implementation of the care treatment plan, and participate in quality of care initiatives and reviews. The provider serves as the entry point into the health care system for the member. The PCP is responsible for including, but not limited to the providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services and maintaining the continuity of care.

**Prior Authorization (PA)** - The act of authorizing specific approved services by the Contractor before they are rendered.

**Program** - The method of provision of Title XIX services to South Carolina beneficiaries as provided for in the Title XIX SC State Medicaid Plan and SCDHHS regulations.

**Provider** –Any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.

**Quality** – As it pertains to external quality review, means the degree to which an **MHN** increases the likelihood of desired health outcomes of its members through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

**Quality Assurance** - The process of assuring that the delivery of health care services provided to members are appropriate, timely, accessible, available and medically necessary.

**Referral Services** - Health care services provided to Medicaid **MHN** Program members outside the Contractor's designated facilities or its subcontractors when ordered and approved by the Contractor.

**Representative** - Any person who has been delegated the authority to obligate or act on behalf of another.

**Rural Health Clinic/RHC** - A South Carolina licensed rural health clinic that is certified by the CMS and receives Public Health Services grants. An RHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. An RHC provides a wide range of primary care and enhanced services in a medically underserved area.

**Routine Care** - Is treatment of a condition which would have no adverse effects if not treated within 24 hours or could be treated in a less acute setting (e.g., physician's office) or by the patient.

**Service Area** - The geographic area in which the Contractor is authorized to accept enrollment of eligible Medicaid **MHN** Program members into the Contractor's plan. The service area must be approved by SCDHHS.

**SCDOI** - South Carolina Department of Insurance.

**SCDHHS** - South Carolina Department of Health and Human Services

**SCDHHS Appeal Regulations** - Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 at S.C. Code Regs. 126-150 et seq. and S.C. Code Ann. §§1-23-310 et seq. (1976, as amended).

**Screen or Screening** - Assessment of a member's physical or mental condition to determine evidence or indications of problems and the need for further evaluation or services.

**Social Security Act** - Title 42, United States Code, Chapter 7, as amended.

**Social Services** - Medical assistance, rehabilitation and other services defined by Title XIX, SCDHHS regulations, and SCDHHS regulations.

**South Carolina State Plan for Medical Assistance** - A plan, approved by the Secretary of SCDHHS, which complies with 42 U.S.C.A. § 1396a, and provides for the methodology of furnishing services to beneficiaries pursuant to Title XIX.

**Subcontract** - A written Contract agreement between the Contractor and a third party to perform a specified part of the Contractor's obligations as specified under the terms of this contract.

**Subcontractor** - Any organization or person who provides any functions or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to SCDHHS under the terms of this Contract.

**Termination** - The member's loss of eligibility for the S.C. Medicaid **MHN** Program and therefore automatic disenrollment from the Contractor's plan.

**Title XIX** - Title 42, United States Code, Chapter 7, subchapter XIX, as amended. (42 U.S.C.A. § 1396 et seq.)

**Urgent Care** - Medical conditions that require attention within forty eight (48) hours. If the condition is left untreated for 48 hours or more, it could develop into an emergency condition.

**Utilization Management** – A process for monitoring the appropriateness of care provided.

**Validation** – The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias, and in accord with standards for data collection and analysis.

**Well Care** - A routine medical visit for one of the following: EPSDT visit, family planning, routine follow-up to a previously treated condition or illness, adult and/or any other routine visit for other than the treatment of an illness.

**WIC** - The Supplemental Food Program for Women, Infants and Children which provides nutrition counseling, nutrition education and nutritious foods to pregnant and postpartum women, infants and children up to the age of two or children deemed nutritional deficient are covered up to age five who have a low income and who are determined to be at nutritional risk.