

**CONTRACT**

**BETWEEN**

**SOUTH CAROLINA**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

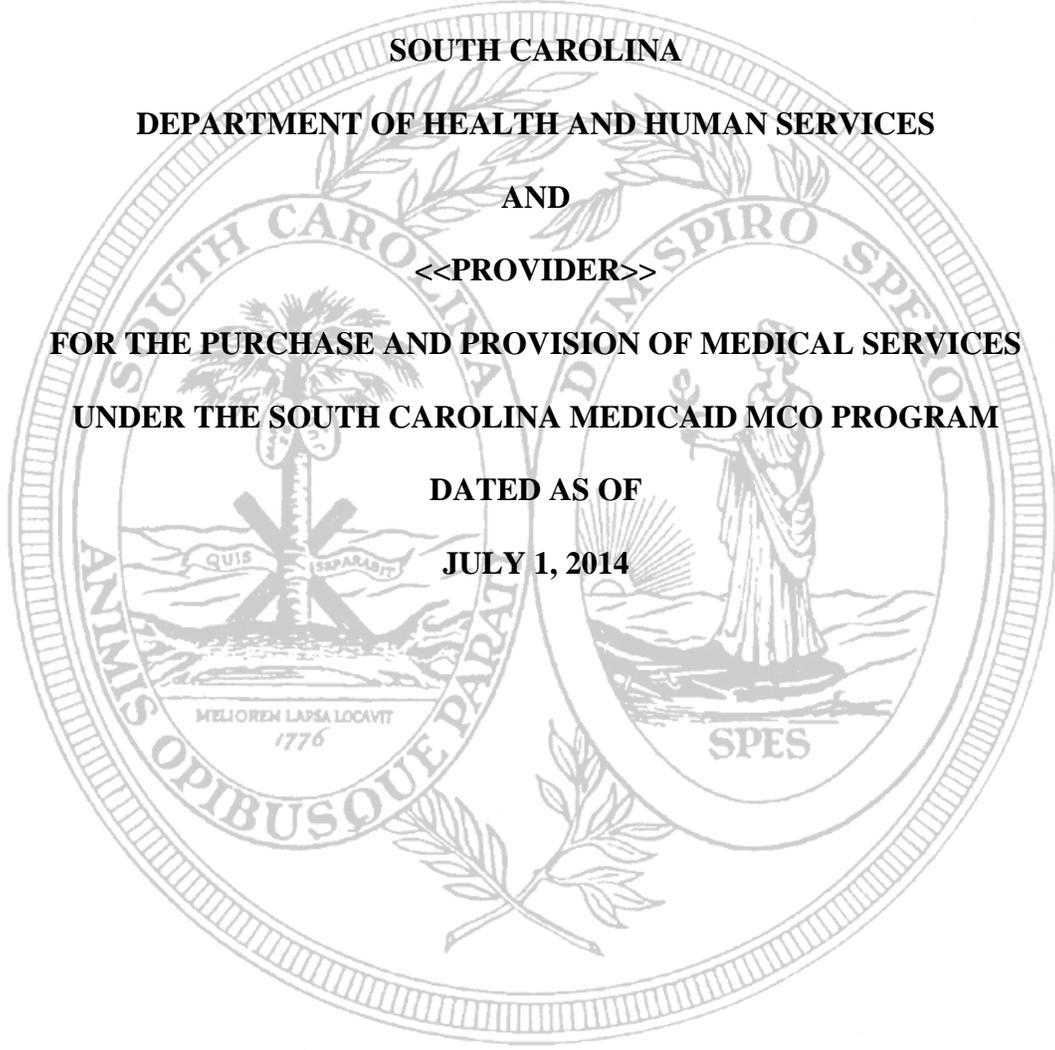
**AND**

**<<PROVIDER>>**

**FOR THE PURCHASE AND PROVISION OF MEDICAL SERVICES  
UNDER THE SOUTH CAROLINA MEDICAID MCO PROGRAM**

**DATED AS OF**

**JULY 1, 2014**



Contract Number

## TABLE OF CONTENTS

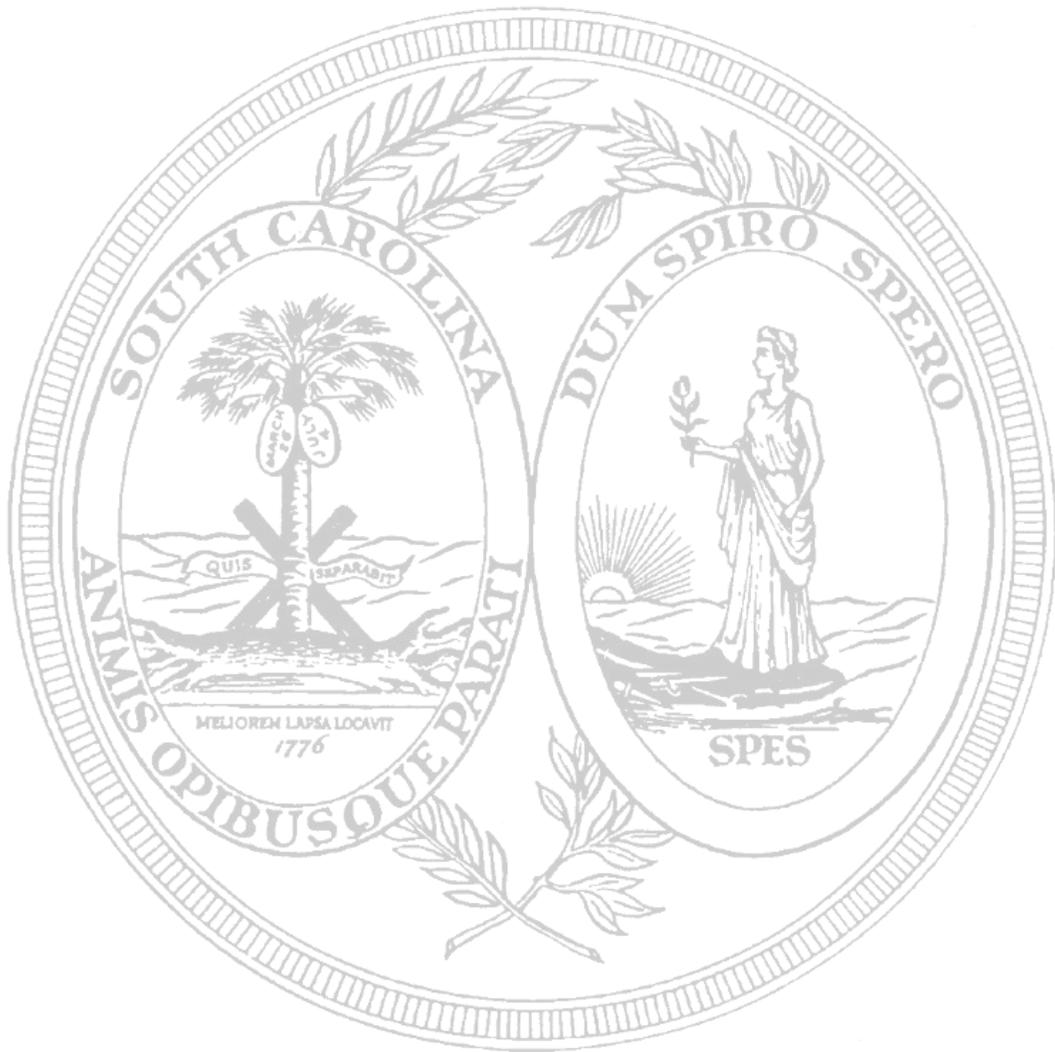
RECITALS .....	1
<b>1 GENERAL PROVISIONS .....</b>	<b>2</b>
1.1 Effective Date and Term .....	2
1.2 Notices .....	2
1.3 Definitions.....	3
1.4 Entire Agreement .....	3
1.5 Federal Approval of Contract .....	3
1.6 Medicaid Managed Care Organization Requirements .....	3
<b>2 CONTRACTOR ADMINISTRATIVE REQUIREMENTS .....</b>	<b>4</b>
2.1 Delegation of Authority .....	4
2.2 CONTRACTOR Administration and Management .....	5
2.3 Credentialing .....	14
2.4 Subcontractor Requirements .....	14
2.5 Immunization Data.....	15
2.6 Provider Enrollment.....	15
<b>3 ELIGIBILITY AND ENROLLMENT PROCESS .....</b>	<b>16</b>
3.1 Enrollment.....	16
3.2 Enrollment Process .....	16
3.3 Disenrollment Process.....	20
3.4 Notification to CONTRACTOR of Membership.....	24
3.5 Maximum Enrollment.....	24
3.6 Suspension and/or Discontinuation of Enrollment .....	26
3.7 Redetermination Notice .....	26
3.8 Member Call Center.....	27
3.9 Member Handbook .....	30
3.10 Provider Directory.....	34
3.11 Billing and Reconciliation .....	35
3.12 Member Education.....	35
3.13 Member Communication .....	36
3.14 Enrollment and Disenrollment Process.....	38
<b>4 SERVICES.....</b>	<b>40</b>
4.1 Core Benefits for the South Carolina Medicaid Managed Care Program.....	40
Table 4.1 List of Core Benefits .....	41
4.2 Service Limits .....	43
4.3 Out-of-Network Coverage .....	43
4.4 Second Opinions .....	43
4.5 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Well Child Visits .....	44
4.6 Emergency Medical Services.....	44

4.7	Pharmacy / Prescription Drugs .....	47
4.8	Hysterectomies.....	50
4.9	Sterilization .....	50
4.10	Limitations of Abortions.....	50
4.11	Medical Services for Special Populations.....	51
4.12	Targeted Case Management (TCM) Services .....	51
4.13	School-Based Services.....	52
4.14	Institutional Long-Term Care (LTC) Facilities/Nursing Facilities (NFs).....	52
4.15	Behavioral Health Services .....	53
4.16	Communicable Disease Services .....	53
4.17	Member Incentives.....	53
4.18	Additional Services.....	54
4.19	Excluded Services.....	55
4.20	Medical Necessity Determination.....	55
4.21	Moral and Religious Objection.....	56
<b>5</b>	<b>CARE COORDINATION .....</b>	<b>56</b>
5.1	Care Management .....	56
5.2	Transition of Care .....	57
5.3	Continuity of Care.....	60
5.4	Coordination of Referral(s) Outside of Core Benefits .....	61
5.5	Health Homes (Section 2703) and Care Coordination.....	62
<b>6</b>	<b>NETWORKS .....</b>	<b>62</b>
6.1	General Requirements.....	62
6.2	Provider Network.....	64
6.3	Attestation(s).....	70
6.4	Regional Provider Networks .....	70
<b>7</b>	<b>PAYMENTS.....</b>	<b>72</b>
7.1	Financial Management.....	72
7.2	Capitation Payments from the Department to CONTRACTOR.....	72
7.3	Payments from CONTRACTOR to Subcontractor.....	74
7.4	Payment Standards.....	75
7.5	Prohibited Payments .....	76
7.6	Return of Funds.....	76
<b>8</b>	<b>UTILIZATION MANAGEMENT .....</b>	<b>77</b>
8.1	Management.....	77
8.2	CONTRACTOR Utilization Management (UM) Program Requirements.....	77
8.3	Practice Guidelines .....	78
8.4	Service Authorization .....	79
8.5	Timeframe of Service Authorization Decisions.....	80
8.6	Standard Service Authorization .....	80
8.7	Expedited Service Authorization .....	80
8.8	Exceptions to Service Authorization Requirements .....	81
8.9	Out-of-Network Use of Non-Emergency Services .....	81
<b>9</b>	<b>GRIEVANCE AND APPEAL PROCEDURES.....</b>	<b>82</b>
9.1	General Procedures .....	82
9.2	General Requirements for CONTRACTOR Grievance System.....	82
9.3	Notice of Grievance and Appeals Procedures.....	83
9.4	Grievance/Appeal Records and Reports .....	83

9.5	Handling of Grievances and Appeals.....	84
9.6	Notice of Action.....	85
9.7	Resolution and Notification .....	87
9.8	Continuation of Benefits while the CONTRACTOR-Level Appeal and the State Fair Hearing are Pending.....	90
9.9	Grievance System Information .....	91
9.10	Effectuation of Reversed Appeal Resolutions .....	91
9.11	Provider Appeals System.....	92
10	<b>THIRD PARTY LIABILITY .....</b>	<b>94</b>
10.1	General.....	94
10.2	Department Responsibilities .....	95
10.3	CONTRACTOR Responsibilities .....	95
10.4	Cost Avoidance .....	96
10.5	Post-Payment Recoveries.....	96
10.6	Retroactive Eligibility for Medicare .....	97
10.7	Third-Party Liability Reporting Disenrollment Requests .....	97
10.8	Third-Party Liability Recoveries by the Department.....	98
10.9	Reporting Requirements .....	98
11	<b>PROGRAM INTEGRITY .....</b>	<b>98</b>
11.1	General.....	98
11.2	CONTRACTOR Program Integrity and Compliance Programs.....	99
11.3	CONTRACTOR Subcontracting Review and Approval Procedures.....	103
11.4	Provider Review, Investigation, and Fraud/Abuse Reporting Requirements .....	103
11.5	Recoveries and Provider Refunds .....	105
11.6	Reporting Requirements for Program Integrity .....	107
11.7	Ownership and Control.....	107
11.8	CONTRACTOR Providers and Employees - Exclusions, Debarment, and Terminations .....	108
11.9	Prohibited Affiliations with Individuals Debarred by Federal Agencies.....	110
11.10	Provider Termination / Denial of Credentials.....	110
11.11	Information Related to Business Transactions .....	111
11.12	Information on Persons Convicted of Crimes.....	111
12	<b>MARKETING PROGRAM.....</b>	<b>111</b>
12.1	General Marketing Requirements .....	111
12.2	Prior Approval of Marketing Materials.....	112
12.3	Guidelines for Marketing Materials and Activities.....	112
13	<b>REPORTING REQUIREMENTS .....</b>	<b>112</b>
13.1	General Requirements.....	112
13.2	Reporting Requirements .....	115
	Table 13.2. Reporting Requirements, by Report, by Frequency, by Submission Due Date and Effective Date. ....	116
14	<b>ENCOUNTER DATA, REPORTING AND SUBMISSION REQUIREMENTS. 121</b>	
14.1	General Data Requirements .....	121
14.2	Encounter Data.....	123
14.3	Errors and Encounter Validation.....	128
14.4	System and Information Security and Access Management Requirements.....	132
15	<b>QUALITY ASSESSMENT, MONITORING AND REPORTING .....</b>	<b>134</b>

15.1	Quality Assessment and Performance Improvement (QAPI) .....	134
15.2	Performance Improvement Projects (PIP) .....	136
15.3	Member Satisfaction Survey .....	137
15.4	Quality Performance Measures .....	138
15.5	CONTRACTOR Quality Withhold and Bonus Program .....	139
15.6	Minimum Performance for Withhold Measures .....	140
15.7	Value Oriented Contracting (VOC) .....	141
15.8	NCQA Accreditation.....	143
15.9	External Quality Review (EQR) .....	143
15.10	Provider Preventable Conditions .....	144
<b>16</b>	<b>DEPARTMENT'S RESPONSIBILITIES .....</b>	<b>144</b>
16.1	Department Contract Management .....	144
16.2	Payment of Capitated Rate.....	145
16.3	Notification of Medicaid Managed Care Program Policies and Procedures.....	145
16.4	Quality Assessment and Monitoring Activities .....	145
16.5	Fee-for-Service (FFS) Reporting to MCOs.....	146
16.6	Request for Plan of Correction.....	146
16.7	External Quality Review .....	146
16.8	Marketing .....	146
16.9	Grievances/Appeals .....	147
16.10	Training .....	147
<b>17</b>	<b>TERMINATION AND AMENDMENTS .....</b>	<b>147</b>
17.1	Termination.....	147
17.2	Termination under Mutual Agreement.....	147
17.3	Termination by Department for Breach .....	147
17.4	Termination for Unavailability of Funds .....	148
17.5	Termination for CONTRACTOR Insolvency, Bankruptcy, Instability of Funds .....	148
17.6	Termination by the CONTRACTOR .....	149
17.7	Termination for Loss of Licensure or Certification .....	149
17.8	Termination for Noncompliance with the Drug Free Workplace Act.....	149
17.9	Termination for Actions of Owners/Managers .....	149
17.10	Non-Renewal .....	150
17.11	Termination Process .....	150
17.12	Amendments and Rate Adjustments.....	154
<b>18</b>	<b>AUDITS, FINES AND LIQUIDATED DAMAGES .....</b>	<b>155</b>
18.1	Audit .....	155
18.2	Liquidated Damages for Failure to Meet Contract Requirements .....	156
18.3	Corrective Action Plan.....	160
18.4	Sanctions .....	160
18.5	Plan of Correction Required (Contract Non-Compliance).....	162
<b>19</b>	<b>TERMS AND CONDITIONS .....</b>	<b>163</b>
19.1	General Contractual Condition .....	163
19.2	HIPAA Compliance .....	164
19.3	Safeguarding Information .....	164
19.4	HIPAA Business Associate.....	164
19.5	Release of Records.....	164
19.6	Confidentiality of Information .....	165
19.7	Integration .....	165

19.8	Hold Harmless .....	165
19.9	Hold Harmless as to the Medicaid Managed Care Program Members .....	166
19.10	Notification of Legal Action.....	167
19.11	Non-Discrimination .....	167
19.12	Safety Precautions .....	167
19.13	Loss of Federal Financial Participation (FFP).....	168
19.14	Sharing of Information .....	168
19.15	Applicable Laws and Regulations .....	168
19.16	Independent Contractor .....	169
19.17	Governing Law and Place of Suit.....	169
19.18	Severability.....	170
19.19	Copyrights .....	170
19.20	Subsequent Conditions .....	170
19.21	Incorporation of Schedules/Appendices .....	170
19.22	Titles.....	170
19.23	Political Activity.....	170
19.24	Force Majeure.....	171
19.25	Conflict of Interest.....	171
19.26	Department Policies and Procedures .....	172
19.27	State and Federal Law .....	172
19.28	Contractor's Appeal Rights .....	172
19.29	Collusion/Anti-Trust.....	173
19.30	Inspection of Records .....	173
19.31	Non-Waiver of Breach.....	173
19.32	Non-Assignability.....	174
19.33	Legal Services.....	174
19.34	Attorney's Fees .....	174
19.35	Retention of Records .....	174
APPENDIX A.....		1
APPENDIX B.....		1
APPENDIX C.....		1
APPENDIX D.....		1



CONTRACT BETWEEN SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES AND STANDARD MCO CONTRACTOR FOR THE PURCHASE AND PROVISION OF MEDICAL SERVICES UNDER THE SOUTH CAROLINA MEDICAID MCO PROGRAM DATED AS OF July 1, 2014.

This Contract is entered into as of the first day of July 2014 by and between the South Carolina Department of Health and Human Services, Post Office Box 8206, 1801 Main Street, Columbia, South Carolina, 29202-8206, hereinafter referred to as "Department" and <<Provider Address>>, hereinafter referred to as "CONTRACTOR".

RECITALS

WHEREAS, the Department is the single state agency responsible for the administration of the South Carolina State Plan for Medical Assistance under Title XIX of the Social Security Act (State Plan) and makes all final decisions and determinations regarding the administration of the Medicaid program; and

WHEREAS, consistent with the state plan amendment approved by the Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS), the Department desires to enter into a risk based contract with the CONTRACTOR, a South Carolina domestic licensed Health Maintenance Organization (HMO) which meets the definition of a Managed Care Organization (MCO); and

WHEREAS, the CONTRACTOR is an entity qualified to enter into a risk based contract in accordance with § 1903(m) of the Social Security Act and 42 CFR Part 438 (2008, as amended), including any amendments hereto, and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 CFR 438.2; and

WHEREAS, the CONTRACTOR is licensed as a domestic HMO by the South Carolina Department of Insurance (SCDOI) pursuant to S.C. Code Ann. §38-33-10 et. seq., (Supp. 2000, as amended) and 25A S.C. Code Ann. Regs. 69-22 (Supp. 2000, as amended) and meets the definition of a MCO; and

WHEREAS, the CONTRACTOR warrants that it is capable of providing or arranging for health care services provided to covered persons for which it has received a capitated payment; and

WHEREAS, the CONTRACTOR is engaged in said business and is willing to provide such health care services to Medicaid Managed Care Members upon and subject to the terms and conditions stated herein; and

NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties have agreed and do hereby enter into this Contract according to the provisions set forth herein:

# 1 GENERAL PROVISIONS

## 1.1 Effective Date and Term

- 1.1.1 This Contract shall be effective no earlier than the date it has been approved by CMS, and shall continue in full force and effect from July 1, 2014 until June 30, 2016, unless terminated prior to that date by provisions of this Contract. The parties agree that certain deliverables required under this Contract, including but not necessarily limited to reports, and may be due on dates that may occur outside of the term of this Contract. In the event that deliverables are due after the termination of this contract, CONTRACTOR agrees to provide those deliverables.

## 1.2 Notices

- 1.2.1 Whenever notice is required to the other party, pursuant to this Contract, it shall be made in writing and delivered to that party. Delivery shall be deemed to have occurred if made in person and a signed receipt is obtained; if delivered by nationally recognized overnight carrier and a receipt is obtained; or if three (3) calendar days have elapsed after posting when sent by registered or certified mail, return receipt requested. Notices shall be addressed as follows:

In case of notice to CONTRACTOR:

«provider»  
«Address 1»  
«citystatezip»

In case of notice to the Department:

South Carolina Department of Health and Human Services  
Deputy Director, Health Services  
1801 Main Street  
Post Office Box 8206  
Columbia, South Carolina 29202-8206

cc: Program Director Health Services Policy  
Program Director Health Services Operations  
Contracts

- 1.2.2 Said notices shall become effective on the date specified within the notice, unless otherwise provided herein. Either party may change its address for notification purposes by mailing a notice stating the change, effective date of the change and setting forth the new address. If different representatives are designated after execution of this Contract, notice of the new representative will be rendered in writing to the other party and attached to originals of this Contract.

### **1.3 Definitions**

- 1.3.1 The definitions and contractual terms used in this Contract shall be construed and/or interpreted by the Department including, but not necessarily limited to, the definitions set forth in Appendix A.

### **1.4 Entire Agreement**

- 1.4.1 The CONTRACTOR shall comply with all the provisions of the Contract, including amendments and appendices, and shall act in good faith in the performance of the provisions of said Contract. The CONTRACTOR shall be bound by the contractual requirements stated herein. Further operational guidance regarding the contractual requirements will be detailed in applicable Provider Manuals and the Managed Care Policy & Procedure Manual. In the event of a dispute between the CONTRACTOR and the Department, the CONTRACTOR acknowledges and agrees that the Department's interpretation shall rule. The CONTRACTOR agrees that failure to comply with the provisions of this Contract may result in the assessment of liquidated damages, sanctions and/or termination of the Contract in whole or in part, as set forth in this Contract. The CONTRACTOR shall comply with all applicable Department policies and procedures and federal laws and regulation in effect throughout the duration of this Contract period. The CONTRACTOR shall comply with all Department handbooks, bulletins and manuals relating to the provision of services under this Contract. The CONTRACTOR agrees that it is responsible for being familiar with all relevant Department policies, procedures, handbooks, bulletins, and manuals that relate in any way to the provisions of this agreement. Where the provisions of the Contract differ from the requirements set forth in the handbooks and/or manuals, then the Contract provisions shall control.
- 1.4.2 The Department, at its discretion, will issue Medicaid bulletins to inform the CONTRACTOR of changes in policies and procedures that may affect this Contract. The Department is the only party to this Contract that may issue Medicaid bulletins.

### **1.5 Federal Approval of Contract**

- 1.5.1 Pursuant to 42 C.F.R. § 438.806, this Contract and all terms and conditions stated herein are subject to prior approval by the CMS Regional Office. If CMS does not approve this Contract, then this Contract will be considered null and void.

### **1.6 Medicaid Managed Care Organization Requirements**

- 1.6.1 The CONTRACTOR must at all times comply with all applicable South Carolina Department of Insurance (SCDOI) requirements and must also continue to meet all applicable requirements listed under Requirements for Certification as a Managed Care Organization, contained within the Department's Managed Care Policy & Procedure Manual.

## 2 CONTRACTOR ADMINISTRATIVE REQUIREMENTS

### 2.1 Delegation of Authority

- 2.1.1 The CONTRACTOR shall oversee and remain accountable for all functions and responsibilities of the CONTRACTOR arising pursuant to this Contract, including any functions and/or responsibilities the CONTRACTOR delegates to a Subcontractor, partner, affiliate, or other party. Agreements between the CONTRACTOR and Providers do not constitute delegations of CONTRACTOR functions and responsibilities for purposes of this contract, as CONTRACTOR obtains rather than delegates such services. Also, agreements between the CONTRACTOR and third parties for the performance of functions not specifically required of the CONTRACTOR pursuant to this Contract are not deemed delegations of CONTRACTOR functions and responsibilities for purposes of this Section. In addition to the provisions set forth in this Section and Appendix D Subcontracts, CONTRACTOR agrees to the following provisions:
- 2.1.1.1 All delegations of services must be made pursuant to a written agreement. The written agreement shall specify the delegated activities and reporting responsibilities of the delegate. The agreement shall also provide for revoking the delegation or imposing other sanctions if the delegate's performance is inadequate.
  - 2.1.1.2 Prior to delegation, the CONTRACTOR shall conduct an initial on-site review and evaluate a prospective delegate's ability to perform the activities to be delegated. The Department may require delegates performing the following activities to be accredited or actively pursuing accreditation by a Nationally Recognized Accrediting body: quality improvement, utilization management, credentialing, and complaints and grievances.
  - 2.1.1.3 The CONTRACTOR shall monitor the delegate's performance on an ongoing basis and at least once per year must conduct a review of the subcontractor performance.
  - 2.1.1.4 If the CONTRACTOR identifies deficiencies or areas for improvement related to the delegate's performance of the delegated activity, the CONTRACTOR and the delegate shall take corrective action.
  - 2.1.1.5 If the CONTRACTOR's delegate subcontracts any of the delegated activity to another, the CONTRACTOR's rights and obligations set forth in this Section shall not be amended or altered, and all delegates and sub-delegates shall remain subject to the requirements of this Section. Additionally, the Department must receive prior notice of any further delegation by the CONTRACTOR's delegate.
  - 2.1.1.6 The CONTRACTOR and all delegates of the CONTRACTOR must be in compliance with the requirements in 42 CFR § 438.230.

## **2.2 CONTRACTOR Administration and Management**

### **2.2.1 Administrative Staffing Requirements**

- 2.2.1.1 The CONTRACTOR shall have in place the organizational, operational, managerial and administrative systems capable of fulfilling all contract requirements.
- 2.2.1.2 The CONTRACTOR shall at a minimum operate Monday through Friday, 8am to 6pm ET excluding state holidays.
- 2.2.1.3 For the purposes of this contract, the CONTRACTOR shall not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549 [42 CFR §§ 438.610 (a) & (b); 1001.1901(b); 1003.102(a)(2).].
- 2.2.1.4 The CONTRACTOR is obligated to screen all employees and subcontractors to determine whether any of them have been excluded from participation in any State or Federal health care programs.
- 2.2.1.5 The CONTRACTOR shall ensure that all staff, Providers and Subcontractors have appropriate training, education, experience, liability coverage and orientation to fulfill the requirements of their positions.
- 2.2.1.6 The CONTRACTOR must employ sufficient personnel, of appropriate education, training, experience, and/or licensure to ensure that the requirements set forth in this Contract are met in a timely fashion.
- 2.2.1.7 If the CONTRACTOR does not maintain compliance with contractual obligations, the Department may employ additional monitoring and regulatory action. This action may include, but is not limited to, requiring the CONTRACTOR to hire additional staff and imposition of liquidated damages or sanctions identified in this Contract.
- 2.2.1.8 The CONTRACTOR shall be responsible for costs associated with on-site audits or other oversight activities that result when functions are located outside of the State of South Carolina.
- 2.2.1.9 For positions that are not identified as Full-Time Employee (FTE), an individual staff member is limited to occupying a maximum of two of the Key Staff positions listed below, unless prior approval is obtained from the Department.

2.2.1.10 The CONTRACTOR shall submit to the Department on an annual basis and upon request by the Department, a current organizational chart depicting all functions including mandatory functions, number of employees in each functional department and key managers responsible for the functions.

2.2.1.11 The CONTRACTOR must document, for each Key Staff position, the portion of time allocated to each Medicaid contract as well as all other lines of business.

2.2.1.12 If, at any point, the CONTRACTOR fails to maintain compliance with contractual obligations, the Department reserves the right to evaluate staffing allocations and require staffing enhancements in order to ensure adherence to established requirements.

2.2.2 **Key Personnel**

2.2.2.1 The CONTRACTOR's staff must include, but is in no way limited to, the positions identified in Table 2.1.

2.2.2.2 The Department reserves the right to approve or disapprove all key personnel (initial or replacement) prior to their assignment with the CONTRACTOR.

2.2.2.3 If, at any time, an individual identified as Key Personnel in Table 2.1 leaves or the position is otherwise changed after execution of this Contract, notice of the new representative or position description shall be rendered in writing to the Department within ten (10) business days of the change.

2.2.3 **Additional Required Staff**

2.2.3.1 In addition to the key staff identified in Table 2.1, CONTRACTOR shall employ sufficient staff to effectively manage operations. Such staff shall include, but is in no way limited to the staff identified in Table 2.2.

**Table 2.1.** Key Personnel, by Position, by In- and Out-of-State, July 1, 2014

POSITIONS <sup>1</sup>	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE# <sup>2</sup>	IN-STATE South Carolina <sup>3</sup>	Specific to Profession	IN-STATE South Carolina	
Administrator (CEO, COO, Executive Director, etc.)	The CONTRACTOR must have a full-time administrator with clear authority over general administration and implementation of requirements set forth in the Contract, including responsibility to oversee the budget and accounting systems implemented by the CONTRACTOR, and have the authority to direct and prioritize work, regardless of where performed.	1.0	Required			10/01/2014
Chief Financial Officer (CFO)	The Chief Financial Officer (CFO) oversees the budget and accounting systems implemented by the CONTRACTOR. An internal auditor shall ensure compliance with adopted standards and review expenditures for reasonableness and necessity					07/01/2014
Contract Account Manager	Contract Account Manager who will serve as the primary point-of-contact between CONTRACTOR and the Department. The primary functions of the Contract Account Manager may include but are not limited to coordinate the tracking and submission of all contract deliverables; field and coordinate responses to Departmental inquiries, and coordinate the preparation and execution of contract requirements such as random and periodic audits and ad hoc visits.	1.0	Required			10/01/2014
Medical Director	A physician licensed in the State of South Carolina to serve as medical director to oversee and be responsible for the proper provision of covered Core Benefits to Medicaid Managed Care Program members under this Contract. The medical director must have substantial involvement in the Quality Assessment activities	1.0	Required	Required	Required	10/01/2014
Pharmacy Director	Pharmacy Director must be appropriately licensed as a Pharmacist in the state in which they operate.			Required		10/01/2014

**Table 2.1.** Key Personnel, by Position, by In- and Out-of-State, July 1, 2014

POSITIONS <sup>1</sup>	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE# <sup>2</sup>	IN-STATE South Carolina <sup>3</sup>	Specific to Profession	IN-STATE South Carolina	
Behavioral Health (BH) Coordinator	Behavioral Health (BH) Coordinator shall be a behavioral health professional. The BH Coordinator shall devote sufficient time to assure the CONTRACTOR's Behavioral Health Program (BH) is implemented per Department requirements.		Not Required			07/01/2014
Quality Improvement (QI) Quality and/or Management (QM) Coordinator, Manager, Director	Quality Improvement Director may have a certification as a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers.	1.0	Required			10/01/2014
Utilization Management (UM) Coordinator, Manager, Director	The Utilization Management Coordinator is responsible for all UM activities, including but not limited to overseeing prior authorizations, referral functions and inpatient certification, including concurrent and retrospective review. The UM Director must have experience in utilization management as specified in this Contract and 42 CFR 438.210. This person shall be a registered nurse (RN) licensed in the State of South Carolina and shall ensure that UM staff have appropriate clinical backgrounds in order to make utilization management decisions. Apart from the RN license, this person may have a certification as a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers, however, the RN license is the only professional credential requirement for this position.			Required	Required	10/01/2014

**Table 2.1.** Key Personnel, by Position, by In- and Out-of-State, July 1, 2014

POSITIONS <sup>1</sup>	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE# <sup>2</sup>	IN-STATE South Carolina <sup>3</sup>	Specific to Profession	IN-STATE South Carolina	
Claims and Encounter Manager/Administrator	The Claims and Encounter Manager/Administrator who shall ensure prompt and accurate provider claims processing. The functions of the Claims Administrator are: Develop and implement claims processing systems capable of paying claims in accordance with State and Federal requirements; Develop processes for cost avoidance; Ensure minimization of claims recoupments; Meet claims processing timelines; and Meet Department encounter reporting requirements.					07/01/2014
Compliance Officer	A designated Compliance Officer is accountable to senior management and will be responsible for program integrity activities required under 42 CFR §438.608	1.0	Required	Required		10/01/2014
Provider Service Manager	Provider Service Manager to coordinate communications between the CONTRACTOR and its subcontractors. There shall be sufficient Provider Services staff to enable providers to receive prompt resolution to their problems or inquiries and appropriate education about participation in the Managed Care program and maintain a sufficient provider network.	1.0	Required			10/01/2014
Member Service Manager	Member Services Manager who shall coordinate communications with members; serve in the role of member advocate; coordinate issues with appropriate areas within the organization; resolve member inquiries/problems and meet standards for resolution, telephone abandonment rates and telephone hold times; and assist members when necessary to access culturally competent, high quality integrated medical and behavioral health care.	1.0	Required			10/01/2014

**Table 2.1.** Key Personnel, by Position, by In- and Out-of-State, July 1, 2014

POSITIONS <sup>1</sup>	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE# <sup>2</sup>	IN-STATE South Carolina <sup>3</sup>	Specific to Profession	IN-STATE South Carolina	
Legal	Staff assigned to provide legal and technical assistance with and for the Department’s legal staff.					07/01/2014
Interagency Liaison	CONTRACTOR shall have an Interagency Liaison who shall be responsible for coordinating the provision of services with HCBS Waivers, community resources, SC DHHS and other State agencies, and any other community entity that traditionally provides services for Medicaid Managed Care Members.		Required			10/01/2014
Other Medical Personnel	Clinical personnel must be appropriately licensed and/or certified within their profession and within the state(s) of which they operate.		Not Required			07/01/2014
Notes: <sup>1</sup> Key position identified in this contract <sup>2</sup> FTE# = Full-Time Employee ( <i>aka</i> FTE) and is defined as an employee that works a minimum of thirty-two (32) hours per week. <sup>3</sup> In the Column titled “Located In-State” a designation of “Required” means that the position must be located within the State of South Carolina.						

**Table 2.2.** Additional Required Staff, July 1, 2014

POSITIONS	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE#	IN-STATE South Carolina	Specific to Profession	IN-STATE South Carolina	
Utilization Review Staff	Responsible for prior authorization and current reviews. This staff shall include but is not limited to licensed nurses, physicians and/or physician's assistants.			Required		10/01/2014
Member Services Staff	Responsible for enabling prompt resolution to member inquiries/problems.					07/01/2014
Provider Services Staff	Located in South Carolina and capable of ensuring that providers receive prompt responses and assistance.		Required			10/01/2014
Network Management Claims Processing Staff	Ensure the timely and accurate processing of original claims, resubmissions and overall adjudication of claims.					07/01/2014

**Table 2.2.** Additional Required Staff, July 1, 2014

POSITIONS	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE#	IN-STATE South Carolina	Specific to Profession	IN-STATE South Carolina	
Network Management Encounter Processing Staff	Ensure the timely and accurate processing and submission to the Department of encounter data and reports.					07/01/2014
Quality Assessment and Performance Improvement Staff	Sufficient staff qualified by training and experience to be responsible for the operation and success of the Quality Assessment and Performance Improvement program (QAPI). The QAPI staff shall be accountable for quality outcomes in all of the CONTRACTOR's own network providers, as well as subcontracted providers, as stated in 42 CFR §§438.200 – 438.242					07/01/2014
Case Management Staff	Located in South Carolina and provide care coordination and transition of care for members.		Required			10/01/2014

#### 2.2.4 **Ongoing-Training**

- 2.2.4.1 The CONTRACTOR shall be responsible for training all of its employees, network Providers, and Subcontractors to ensure adherence to the Medicaid Managed Care Program policies and procedures and Medicaid laws and regulations.
- 2.2.4.2 The CONTRACTOR shall be responsible for conducting ongoing training on Medicaid Managed Care Program policies and distribution of updates for its network Providers/Subcontractors.
- 2.2.4.3 The CONTRACTOR shall hold training sessions in several regional locations throughout the state at least once a year.
- 2.2.4.4 The CONTRACTOR must submit a training plan to the Department no later than October 1, 2014 and July 1st each year thereafter. The training plan must include dates, times, and location of each training session. The Department reserves the right to attend any and all training programs and seminars conducted by the CONTRACTOR
- 2.2.4.5 The CONTRACTOR shall provide any updates to the training schedule to the Department at least thirty (30) calendar days prior to the actual date of training. See the Managed Care Policy and Procedure Manuals for additional information.

#### 2.2.5 **Licensing Requirements**

- 2.2.5.1 All of the CONTRACTOR's Network Providers must be licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency, as applicable. All of the CONTRACTOR's network Providers/Subcontractors must comply with all applicable statutory and regulatory requirements of the Medicaid program and be eligible to participate in the Medicaid program.
- 2.2.5.2 The CONTRACTOR shall be responsible for assuring that all persons, whether employees, agents, Subcontractors or anyone acting for or on behalf of the CONTRACTOR, are properly licensed at all times under applicable state law and/or regulations and are not debarred, suspended or otherwise ineligible from participation in the Medicaid and/or Medicare program.
- 2.2.5.3 All health professionals and health care facilities used in the delivery of services by or through the CONTRACTOR shall be currently licensed to practice or operate in the State in which the service is delivered. The Department may withhold part or all of the Capitation Payment due the CONTRACTOR if the service is provided or authorized by unlicensed personnel. The Department may also refer the matter to the appropriate licensing authority for action.

2.2.5.3.1 In the event the Department notifies the CONTRACTOR of its discovery that the CONTRACTOR's Subcontractor is not properly licensed by the appropriate authority, the CONTRACTOR shall immediately remove the Subcontractor from its Provider list and the Subcontractor shall discontinue providing services to Medicaid Managed Care Members.

2.2.5.3.2 Upon proper licensing by the appropriate authority and approval by the Department, the CONTRACTOR may reinstate the Subcontractor to provide services to Medicaid Managed Care Members.

## 2.2.6 **Contract Account Manager**

2.2.6.1 The CONTRACTOR shall designate an employee of its administrative staff to act as liaison between the CONTRACTOR and the Department for the duration of the Contract. The Department will identify an employee(s) to serve as the point of contact with CONTRACTOR, unless otherwise specified in this Contract.

2.2.6.2 The CONTRACTOR shall also designate a member of its senior management who shall act as a liaison between the CONTRACTOR's senior management and the Department when such communication is required.

## 2.3 **Credentialing**

2.3.1 The CONTRACTOR must have a written credentialing program that complies with 42 CFR §§ 438.12; 438.206, 438.214, 438.224 and 438.230 (2013) as well as standards defined in the Department's Managed Care Policy and Procedure Manual.

2.3.2 If the CONTRACTOR delegates the credentialing to another party, there shall be a written description of the delegation of credentialing activities. The written description must require the delegate to provide assurance that all licensed medical professionals are credentialed in accordance with Department's credentialing requirements and none of the Subcontractors officers, or employees have been excluded from participating in a federal or state program. The Department will have final approval of the delegated entity.

## 2.4 **Subcontractor Requirements**

### 2.4.1 **Provider Subcontract Requirements**

2.4.1.1 The CONTRACTOR shall provide or assure the provision of all Core Benefits specified in this Contract. The CONTRACTOR may provide these services directly or may enter into subcontracts with Providers who will provide services to the Medicaid Managed Care Members in exchange for payment by the CONTRACTOR for services rendered.

## 2.4.2 **Subcontract Boilerplate Requirements**

- 2.4.2.1 All subcontracts for the provision of services under this Contract shall contain verbatim the language containing all Federal, State and Department requirements as outlined in the appropriate Subcontract Boilerplate contained in Appendix D, which shall supersede all other requirements of the subcontract.
- 2.4.2.2 The CONTRACTOR shall submit a version of each subcontract it intends to use with its Providers and Subcontractor to enable the Department to validate the proper inclusion of Subcontract Boilerplate Requirements. See Appendix D for more details regarding this requirement.

## **2.5 Immunization Data**

- 2.5.1.1 The CONTRACTOR and its subcontracted Providers shall work with the South Carolina Department of Health and Environmental Control (DHEC) to match immunization data with Medicaid Managed Care Member records. The CONTRACTOR will provide the Department with the immunization data. The CONTRACTOR shall require its Subcontractors to provide immunization data on all claims.

## 2.5.2 **Federal Fund Restrictions**

- 2.5.2.1 The CONTRACTOR shall access the Office of Inspector General (OIG) electronic databases on a monthly basis to identify whether any individuals with whom the CONTRACTOR has a relationship are prohibited from receiving Federal funds.

## **2.6 Provider Enrollment**

- 2.6.1 The CONTRACTOR shall ensure that all individuals and entities within its provider network that provide medical services to Medicaid patients enroll with the Department as Medicaid providers. For specific requirements on Provider Enrollment refer to the Department's website at: <https://www.scdhhs.gov/ProviderRequirements>
- 2.6.2 The CONTRACTOR will identify providers that are currently contracted with its plan but not enrolled as required above and assist them with the Medicaid enrollment process.
  - 2.6.2.1 The CONTRACTOR will ensure that all providers that need to enroll with the Department have completed the enrollment process by 10/01/2014.
    - 2.6.2.1.1 The Department at its sole discretion may grant an extension of the provider registration deadline or may grant an extension for an individual provider or provider group.

2.6.2.1.2 If a provider has not completed the required enrollment and the Department has not granted an extension, the provider will be removed from the network, and the CONTRACTOR must provide for transition of care in accordance with Section 5.

### **2.6.3 Centralized Provider Enrollment and Credentialing**

2.6.3.1 The Department intends to partner with external entities for the purposes of centralizing all provider enrollments and credentialing functions.

2.6.3.1.1 These functions include, but are not limited to receiving completed applications, attestations and primary source verification documents and conducting annual provider site visits to ensure compliance with Medicaid requirements.

2.6.3.2 Once the Department signs a contract with an entity(ies), the CONTRACTOR will receive notice and be required to make said entity (ies) responsible for its credentialing and re-credentialing process within one hundred and twenty (120) days of notice from the Department.

2.6.3.2.1 This requirement eases the administrative burden for providers by reducing duplicative submission of information.

2.6.3.3 The CONTRACTOR will continue to be responsible for required credentialing activities throughout the transition to a centralized entity(ies).

2.6.3.3.1 The CONTRACTOR shall have procedures for informing network providers of identified deficiencies, conducting ongoing monitoring of corrective actions, and taking appropriate follow-up actions, such as instituting progressive sanctions and appeal processes.

2.6.3.3.2 The CONTRACTOR shall conduct reassessments to determine if corrective action yields intended results.

## **3 ELIGIBILITY AND ENROLLMENT PROCESS**

### **3.1 Enrollment**

3.1.1 Enrollment in a Medicaid Managed Care Health Plan (“MCO”) will be governed by the approved State Plan that identifies Medicaid Managed Care Members who must enroll with a Health Plan and those who may voluntarily enroll with a Health Plan. Refer to the Managed Care Policy and Procedure Manuals for additional details.

### **3.2 Enrollment Process**

3.2.1 The Department has established an enrollment process for Medicaid managed care through a contracted Enrollment Broker.

### 3.2.2 **Department Responsibilities**

- 3.2.2.1 The Department or its designee is responsible for all enrollment and disenrollment activities for potential and enrolled Medicaid Managed Care Members in accordance with 42 CFR § 438.10(b).

### 3.2.3 **CONTRACTOR Responsibilities**

- 3.2.3.1 The CONTRACTOR, its employees, agents or subcontractors will not distribute enrollment forms and will refer any potential Medicaid Managed Care Member seeking to enroll in a plan to the Department's contracted enrollment broker. Furthermore, the CONTRACTOR, its employees, agents or subcontractors will not enroll a potential member or disenroll any member.

#### 3.2.3.2 **CONTRACTOR Membership**

- 3.2.3.2.1 The Department will notify the CONTRACTOR of the Medicaid eligibles who are enrolled, re-enrolled, or disenrolled from its Health Plan, as specified in this Section of this Contract.

3.2.3.2.1.1 The CONTRACTOR shall contact its Medicaid Managed Care Members, as required in Section 3 of this Contract.

3.2.3.2.2 The CONTRACTOR shall accept Medicaid Managed Care Members in the order in which the Enrollment Broker submits them without restriction (42 CFR §438.6 (d)(1)) as specified by the Department up to the limits specified in the Contract.

3.2.3.2.3 The CONTRACTOR shall not discriminate against Medicaid Managed Care Members on the basis of their health history, health status, need for health care services or adverse change in health status.

3.2.3.2.3.1 This applies to enrollment, re-enrollment or disenrollment from the CONTRACTOR's Health Plan.

3.2.3.2.4 The CONTRACTOR shall comply with transition of care in accordance with Section 5.

#### 3.2.3.2.5 **Enrolling Eligibles in the CONTRACTOR's Plan**

3.2.3.3 If a potentially eligible beneficiary does not select a plan, then the Department or its designee will assign the beneficiary to a Medicaid Managed Care Organization.

3.2.3.4 The Department shall use an algorithm to auto-assign potential members required to enroll in a managed care plan that do not select a Health Plan. The algorithm may be updated by the Department on a periodic basis.

3.2.3.4.1 Factors considered by the algorithm include but are not limited to Health Plan quality and performance measures, plan size and plan's ability to serve beneficiaries.

3.2.3.5 A Medicaid Managed Care Member who is disenrolled due to loss of Medicaid eligibility but regains Medicaid eligibility within sixty (60) calendar days shall automatically be enrolled in the same Medicaid Managed Care Health Plan.

3.2.3.5.1 If Medicaid eligibility is regained after sixty (60) calendar days, the Department's Enrollment Broker will mail an enrollment packet to the beneficiary to select a plan.

3.2.3.5.1.1 The beneficiary may also initiate the re-enrollment process without an enrollment packet.

### 3.2.4 **Enrollment Period**

3.2.4.1 The Medicaid Managed Care Member shall be enrolled for a period of twelve (12) months or until the next open enrollment period, contingent upon continued Medicaid eligibility.

3.2.4.2 Following their initial enrollment into a CONTRACTOR's Health Plan, Medicaid Managed Care Members have ninety (90) days from enrollment in which they may change plans for any reason.

3.2.4.2.1 After the initial ninety (90) day period, Medicaid Managed Care Members shall remain enrolled in the CONTRACTOR's Health Plan for the remaining nine (9) additional months from the effective date of enrollment or until the next annual open enrollment period, unless disenrolled for cause or the Medicaid Managed Care Member becomes ineligible for Medicaid or enrollment in a plan.

3.2.4.3 Annually, the Department will mail a re-enrollment offer.

3.2.4.3.1 Medicaid Managed Care Members will have ninety (90) days from the date the re-enrollment packet is mailed to Medicaid Managed Care Members to determine if they wish to continue to be enrolled with the CONTRACTOR's Health Plan or choose another Health Plan.

3.2.4.3.2 If the member has not chosen another Health Plan by the time of his/her anniversary date, the member will remain with the current Medicaid Managed Care Organization (MCO) and may be disenrolled only for cause.

### 3.2.5 **Enrollment Effective Date**

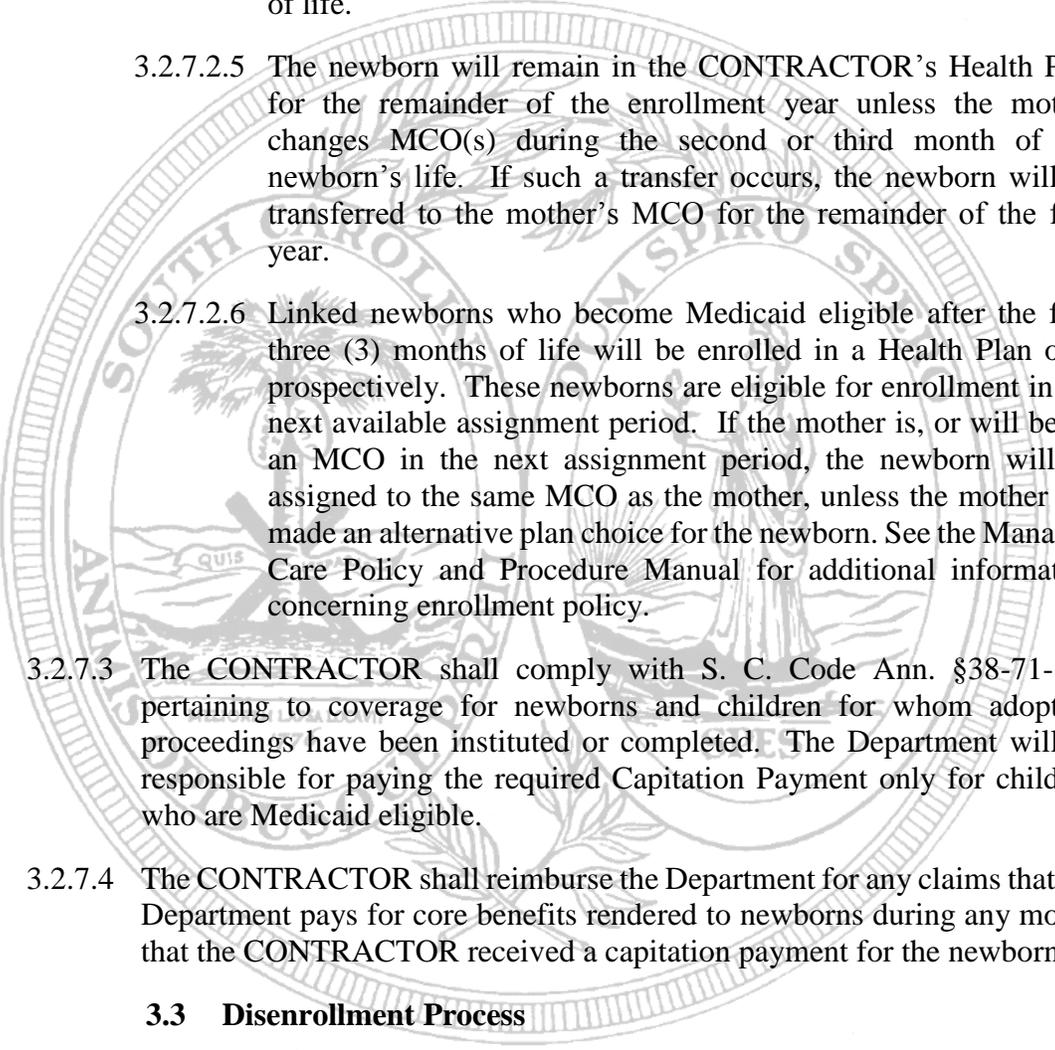
The effective date of enrollment will be the beginning of the month for members specified on the 834.

**3.2.6 Selection or Assignment of a Primary Care Provider (PCP)**

- 3.2.6.1 Each Medicaid Managed Care Member shall be given the opportunity to choose a specific Primary Care Provider (PCP) within the CONTRACTOR's provider network.
- 3.2.6.2 That PCP will be responsible for the provision of primary care services as well as the coordination of all other health care needs in accordance with 42 CFR § 438.208(b).
- 3.2.6.3 Medicaid Managed Care Members who do not choose a PCP by the tenth (10<sup>th</sup>) calendar day of the month in which the member is initially enrolled in the CONTRACTOR's Health Plan, shall be contacted by the CONTRACTOR and assigned a PCP.
- 3.2.6.4 The CONTRACTOR must document its attempts to contact the Medicaid Managed Care Member.
- 3.2.6.5 If the CONTRACTOR is unable to contact the newly assigned Medicaid Managed Care Member, it shall assign a PCP to the Medicaid Managed Care Member.
- 3.2.6.6 If the new Medicaid Managed Care Member contacts the CONTRACTOR after being assigned a PCP and selects a different PCP, the CONTRACTOR must switch the Medicaid Managed Care Member to the new PCP within five (5) business days.
- 3.2.6.7 The CONTRACTOR shall confirm the PCP selection information in a written notice to the Medicaid Managed Care Member.

**3.2.7 Enrollment of Newborns**

- 3.2.7.1 Newborns whose mothers are enrolled in the CONTRACTOR's Health Plan at the time of birth and who are linked to the mother are the CONTRACTOR's responsibility. To assure continuity of care in the crucial first months of the newborn's life, every effort shall be made by the Department to expedite enrollment of newborns into the same Medicaid Managed Care Organization (MCO) as the mother.
- 3.2.7.2 Newborn enrollment for Medicaid Managed Care Members will occur through the following procedures:
  - 3.2.7.2.1 The Department's eligibility staff will attempt to link all newborns to a Medicaid mother when appropriate information is available.
  - 3.2.7.2.2 The CONTRACTOR is responsible for notifying the Department of the birth of an unlinked newborn to an enrolled member.

- 
- 3.2.7.2.3 Linked newborns that become Medicaid eligible within the first three months of life (as determined by the monthly cutoff date) will be eligible for retroactive enrollment into a Health Plan. The effective date of eligibility will be the date of first day of the month for which the child was born.
- 3.2.7.2.4 Retroactive enrollment into the CONTRACTOR's Health Plan will occur if the newborn's mother was enrolled in the CONTRACTOR's Health Plan during the first three (3) months of life.
- 3.2.7.2.5 The newborn will remain in the CONTRACTOR's Health Plan for the remainder of the enrollment year unless the mother changes MCO(s) during the second or third month of the newborn's life. If such a transfer occurs, the newborn will be transferred to the mother's MCO for the remainder of the first year.
- 3.2.7.2.6 Linked newborns who become Medicaid eligible after the first three (3) months of life will be enrolled in a Health Plan only prospectively. These newborns are eligible for enrollment in the next available assignment period. If the mother is, or will be, in an MCO in the next assignment period, the newborn will be assigned to the same MCO as the mother, unless the mother has made an alternative plan choice for the newborn. See the Managed Care Policy and Procedure Manual for additional information concerning enrollment policy.
- 3.2.7.3 The CONTRACTOR shall comply with S. C. Code Ann. §38-71-140 pertaining to coverage for newborns and children for whom adoption proceedings have been instituted or completed. The Department will be responsible for paying the required Capitation Payment only for children who are Medicaid eligible.
- 3.2.7.4 The CONTRACTOR shall reimburse the Department for any claims that the Department pays for core benefits rendered to newborns during any month that the CONTRACTOR received a capitation payment for the newborn.

### **3.3 Disenrollment Process**

- 3.3.1 The Department or its designee is responsible for any disenrollment action to remove a Medicaid Managed Care Member from the CONTRACTOR's Health Plan. The CONTRACTOR shall refer any Member request for disenrollment to the Department or its designee. The CONTRACTOR must comply with provisions of this Section of this Contract.

#### **3.3.2 Member Initiated Disenrollment**

3.3.2.1 A Medicaid Managed Care Member may request disenrollment from the CONTRACTOR's Health Plan (1) for cause, at any time; or (2) without cause, for the reasons listed in Section 3 of this Contract.

3.3.2.2 **Member Initiated Disenrollment Requests**

3.3.2.2.1 Member Initiated Disenrollment Requests may be oral, written or electronic and must be made to the Department's enrollment broker. A Medicaid Managed Care Member's request to disenroll must be acted on by the Department no later than the first day of the second month following the month in which the Medicaid Managed Care Member filed the request. If not, the request shall be considered approved.

3.3.2.3 **Disenrollment Without Cause**

3.3.2.3.1 A Medicaid Managed Care Member may request disenrollment from the CONTRACTOR's Health Plan without cause. Disenrollment without cause will be granted by the Department only in the following circumstances:

3.3.2.3.2 Within ninety (90) days after the member's initial enrollment in a plan;

3.3.2.3.3 Upon automatic reinstatement into a plan if the member regained Medicaid eligibility within sixty (60) days;

3.3.2.3.4 At least once every twelve (12) months thereafter;

3.3.2.3.5 When the Department imposes an intermediate sanction specified in 42 CFR § 438.702 and Section 18 of this Contract.

3.3.2.4 **Disenrollment for Cause**

3.3.2.4.1 A Medicaid Managed Care Member may request disenrollment from the CONTRACTOR's Health Plan for cause at any time. For cause disenrollment requests must be initiated with the Enrollment Broker, who will send the appropriate form to the member for completion. The member is required to contact the Health Plan prior to submitting the completed form to the Enrollment Broker for initial processing.

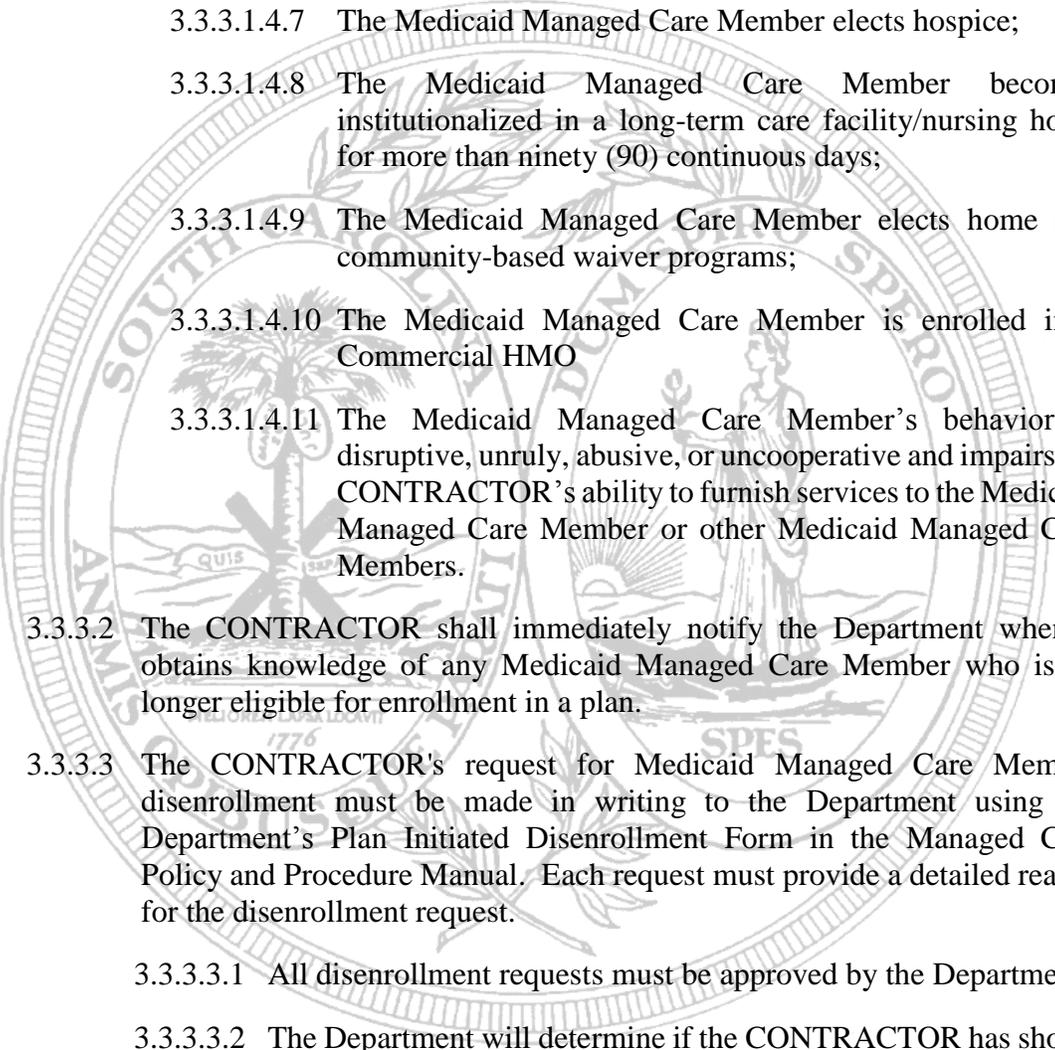
3.3.2.4.2 All disenrollment for cause decisions are made by the Department. The Medicaid Managed Care Member shall have the right to appeal any adverse decision.

3.3.2.4.3 The following are considered for-cause disenrollment(s) by the Medicaid Managed Care Member:

- 3.3.2.4.3.1 The Medicaid Managed Care Member moves out of the CONTRACTOR's service area;
- 3.3.2.4.3.2 The CONTRACTOR's Health Plan does not, because of moral or religious objections, cover the service the Medicaid Managed Care Member seeks;
- 3.3.2.4.3.3 The contract has been terminated by the CONTRACTOR or the Department;
- 3.3.2.4.3.4 The Medicaid Managed Care Member needs related services to be performed at the same time; not all related services are available within the CONTRACTOR's network; and the Medicaid Managed Care Member's PCP or another provider determines that receiving the services separately would subject the Medicaid Managed Care Member to unnecessary risk; and
- 3.3.2.4.3.5 Other reasons, as approved by the Department on a case by case basis, including, but not limited to: poor quality of care; lack of access to Core Benefits; or lack of access to providers experienced in dealing with the Medicaid Managed Care Member's health care needs.

### 3.3.3 **CONTRACTOR Initiated Member Disenrollment**

- 3.3.3.1 The CONTRACTOR may request to disenroll a Medicaid Managed Care Member based upon the following Department approved reasons:
  - 3.3.3.1.1 The CONTRACTOR ceases participation in the Medicaid Managed Care Program;
  - 3.3.3.1.2 The CONTRACTOR ceases participation in the Medicaid Managed Care Member's Service Area;
  - 3.3.3.1.3 The Medicaid Managed Care Member's intentional submission of fraudulent information to gain Medicaid eligibility;
  - 3.3.3.1.4 The Medicaid MCO determines that the Medicaid Managed Care Member is otherwise ineligible for enrollment for the following reasons:
    - 3.3.3.1.4.1 Death of member;
    - 3.3.3.1.4.2 Member moves out of the service area
    - 3.3.3.1.4.3 The CONTRACTOR determines the Medicaid Managed Care Member has Medicare coverage

- 
- The seal of the State of Florida is visible in the background, featuring a palm tree, a sun, and a figure holding a scale, surrounded by the text "SOUTH FLORIDA" and "SPERO".
- 3.3.3.1.4.4 The Medicaid Managed Care Member is placed out of home (i.e. Intermediate Care Facility for the Mentally Retarded [ICF/MR], Psychiatric Residential Treatment Facility [PRTF]);
  - 3.3.3.1.4.5 The member becomes an inmate of a public institution;
  - 3.3.3.1.4.6 The Medicaid Managed Care Member moves out of state or out of the CONTRACTOR's service area;
  - 3.3.3.1.4.7 The Medicaid Managed Care Member elects hospice;
  - 3.3.3.1.4.8 The Medicaid Managed Care Member becomes institutionalized in a long-term care facility/nursing home for more than ninety (90) continuous days;
  - 3.3.3.1.4.9 The Medicaid Managed Care Member elects home and community-based waiver programs;
  - 3.3.3.1.4.10 The Medicaid Managed Care Member is enrolled in a Commercial HMO
  - 3.3.3.1.4.11 The Medicaid Managed Care Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the CONTRACTOR's ability to furnish services to the Medicaid Managed Care Member or other Medicaid Managed Care Members.
- 3.3.3.2 The CONTRACTOR shall immediately notify the Department when it obtains knowledge of any Medicaid Managed Care Member who is no longer eligible for enrollment in a plan.
- 3.3.3.3 The CONTRACTOR's request for Medicaid Managed Care Member disenrollment must be made in writing to the Department using the Department's Plan Initiated Disenrollment Form in the Managed Care Policy and Procedure Manual. Each request must provide a detailed reason for the disenrollment request.
- 3.3.3.3.1 All disenrollment requests must be approved by the Department.
  - 3.3.3.3.2 The Department will determine if the CONTRACTOR has shown good cause to disenroll the Medicaid Managed Care Member, and the Department will give written notification to the CONTRACTOR and the Medicaid Managed Care Member of its decision. The Medicaid Managed Care Member shall have the right to appeal any adverse decision.

- 3.3.3.4 The CONTRACTOR may not request disenrollment because of an adverse change in the Medicaid Managed Care Member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the CONTRACTOR's Health Plan seriously impairs the CONTRACTOR's ability to furnish services to either this particular Medicaid Managed Care Member or other Medicaid Managed Care Members).
- 3.3.3.5 If the CONTRACTOR ceases participation in the Medicaid Managed Care Member's service area or ceases participation in the Medicaid Managed Care Program, the CONTRACTOR shall notify the Department in accordance with the termination procedures in Section 17 of this Contract. The Department will notify Medicaid Managed Care Members and offer them the choice of another Health Plan in their geographic service area. The Enrollment Broker shall assist the Department in transitioning Medicaid Managed Care Members to another Health Plan to ensure access to needed health care services. Costs related to such a transfer are addressed in Section 17 of this Contract.

#### **3.3.4 Department Initiated Member Disenrollment**

- 3.3.4.1 The Enrollment Broker will notify the CONTRACTOR of the Medicaid Managed Care Member's disenrollment. Notification will occur on the daily 834 sent to the CONTRACTOR.

#### **3.4 Notification to CONTRACTOR of Membership**

- 3.4.1 The Enrollment Broker will notify the CONTRACTOR at specified times each month of the Medicaid eligibles that are enrolled, re-enrolled, or disenrolled from the CONTRACTOR's Health Plan for the following month.
- 3.4.2 The CONTRACTOR will receive this notification through electronic media in the 834 file provided by the Enrollment Broker. See the Managed Care Policy and Procedure Manual for record layout.
- 3.4.3 The Department will use its best efforts to ensure that the CONTRACTOR receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or unresolvable differences between the Department and the CONTRACTOR regarding enrollment, disenrollment and/or termination, the Department will be responsible for taking the appropriate action for resolution.

#### **3.5 Maximum Enrollment**

- 3.5.1 The CONTRACTOR shall accept Medicaid Managed Care Members in the order in which they apply, as determined by the Department, up to the limits authorized by the Department and consistent with the processes specified in this contract and the Managed Care Policy and Procedure Manual.

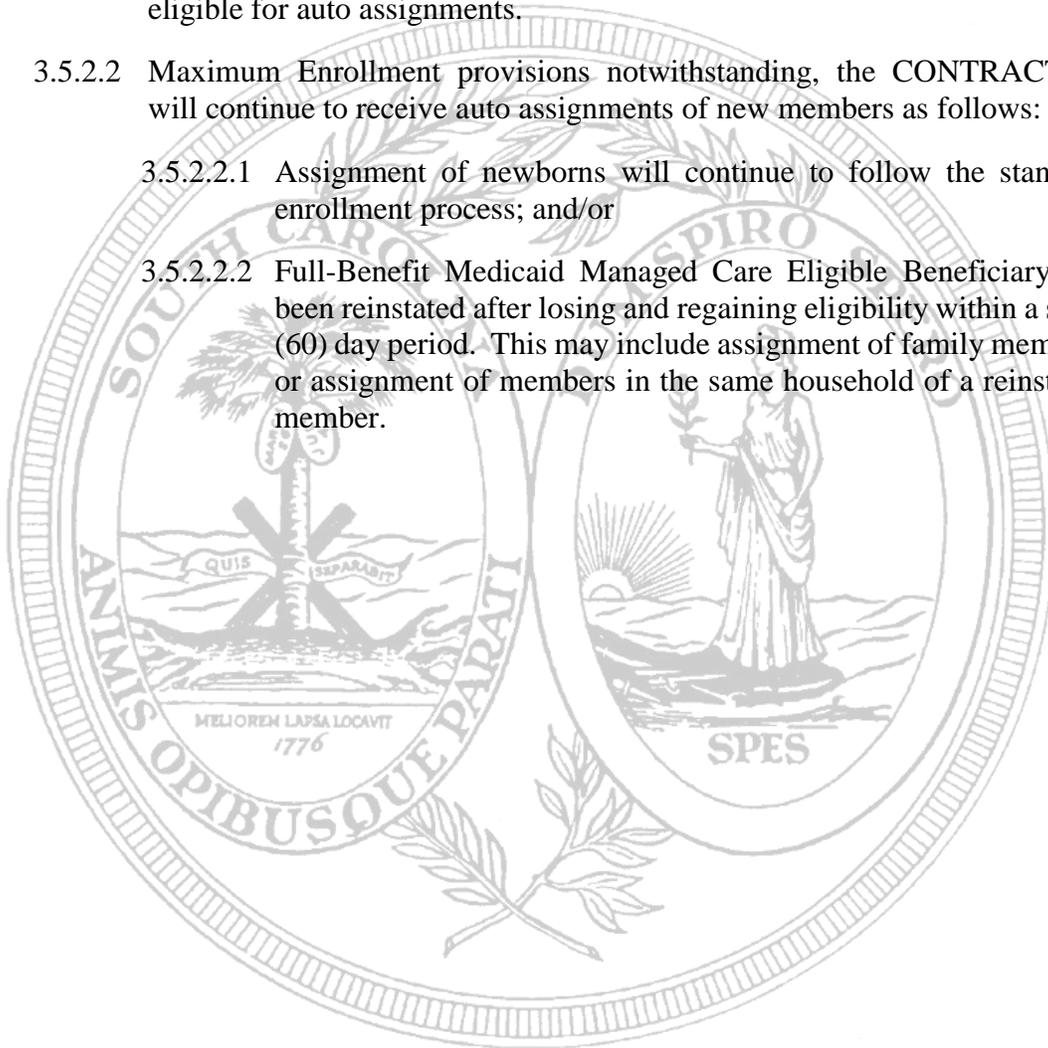
**3.5.2 Maximum Enrollment by Population(s) and Service Area(s)**

3.5.2.1 Effective with implementation of the regional geographic service area model, in the event the CONTRACTOR's enrollment reaches forty-five (45%) percent of the Full-Benefit Medicaid Managed Care Eligible population in a region, the Department will discontinue auto assignments to the CONTRACTOR for a minimum of six (6) months or until enrollment is forty (40%) percent or less of the Full-Benefit Medicaid Managed Care enrollment in a region, at which point the CONTRACTOR will become eligible for auto assignments.

3.5.2.2 Maximum Enrollment provisions notwithstanding, the CONTRACTOR will continue to receive auto assignments of new members as follows:

3.5.2.2.1 Assignment of newborns will continue to follow the standard enrollment process; and/or

3.5.2.2.2 Full-Benefit Medicaid Managed Care Eligible Beneficiary has been reinstated after losing and regaining eligibility within a sixty (60) day period. This may include assignment of family members or assignment of members in the same household of a reinstated member.



### **3.6 Suspension and/or Discontinuation of Enrollment**

#### **3.6.1 Suspension of Enrollment**

- 3.6.1.1 The Department may suspend new enrollment and/or auto assignment when the Department has imposed a sanction or the CONTRACTOR is placed under a Corrective Action in accordance with Section 18.

#### **3.6.2 Discontinuation of Enrollment**

- 3.6.2.1 The Department will discontinue all enrollment(s) in a CONTRACTOR's Health Plan that has provided notice to withdraw from a geographic service area or terminate the contract in accordance with Section 17 of this Contract. The Department shall discontinue all enrollments on the date of the notice submitted by the CONTRACTOR or on the earliest possible date by which such enrollments can be discontinued.

#### **3.6.3 CONTRACTOR Requests to Discontinue Enrollment**

- 3.6.3.1 The CONTRACTOR may submit a request to discontinue receiving Medicaid Managed Care Member enrollment subject to approval by the Department.
- 3.6.3.2 The request must be submitted in writing at least sixty (60) days in advance when the CONTRACTOR has not reached its maximum enrollment limit as specified in Section 3 of this Contract.
- 3.6.3.3 The notification must contain the effective period of the request and the reason for the request.
- 3.6.3.4 The Department retains sole discretion in approving such request, and any approval will result in the discontinuation of all enrollments in the plan including but not limited to new members, reinstatements, etc.

### **3.7 Redetermination Notice**

- 3.7.1 In an effort to minimize the number of disenrollment(s) due to loss of Medicaid eligibility, the Department will provide the CONTRACTOR with a monthly listing of Medicaid Managed Care Members who were mailed an Eligibility Redetermination/Review Form during the month.
- 3.7.2 The term redetermination shall be used interchangeably with renewal of eligibility.
- 3.7.3 The CONTRACTOR may use the redetermination notice information to inform the Medicaid Managed Care Member of the need to reapply for Medicaid eligibility.

- 3.7.4 The CONTRACTOR may also use this information to assist its Medicaid Managed Care Members in taking appropriate action to maintain Medicaid eligibility.

### **3.8 Member Call Center**

- 3.8.1 The CONTRACTOR shall maintain an organized, integrated Medicaid Managed Care Member services call-in center that provides a toll-free number, physically located in the United States, with dedicated staff to respond to member questions including, but not limited to, such topics as:

- 3.8.1.1 Information regarding Primary Care Provider (PCP) selection including registering the Medicaid Managed Care Member's choice;
- 3.8.1.2 Explanation of CONTRACTOR policies and procedures;
- 3.8.1.3 Information regarding prior authorization requirements;
- 3.8.1.4 Information regarding covered services
- 3.8.1.5 Information on Primary Care Providers (PCPs) or specialists;
- 3.8.1.6 Referral process to participating specialists;
- 3.8.1.7 Resolution of service and/or medical delivery problems
- 3.8.1.8 Questions and/or referral requests resulting from the placement of the Member in the Pharmacy Lock-in Program; and
- 3.8.1.9 Member grievances.

### **3.8.2 Call Center Availability and Operation**

#### **3.8.2.1 Toll-Free Number**

- 3.8.2.1.1 The toll-free number must be staffed between the hours of 8:00 a.m. through 6:00 p.m. Eastern Time, Monday through Friday, excluding state declared holidays. The toll-free line shall have an automated system, available twenty-four (24) hours a day, and seven (7) days a week. This automated system must include the capability of providing callers with instructions on what to do in case of an emergency and the option to talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned.

#### **3.8.2.2 Telephone Lines**

- 3.8.2.2.1 The CONTRACTOR shall have sufficient telephone lines to answer incoming calls.

#### **3.8.2.3 Staffing**

3.8.2.3.1 The CONTRACTOR shall ensure sufficient staffing of the call center adjusted for peak call-volume time.

3.8.2.3.2 The Department reserves the right to specify staffing ratio and/or other requirements, if performance standards are not met or it is determined that the call center staffing/processes are not sufficient to meet member needs as determined by the Department.

**3.8.2.4 Telephone Help Line Policies and Procedures**

3.8.2.4.1 The CONTRACTOR must develop telephone help line policies and procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards. The CONTRACTOR shall make the policies and procedures available to the Department for review.

**3.8.2.5 Non-English Speaking Services**

3.8.2.5.1 CONTRACTOR shall ensure that translation services are available for all non-English-speaking callers.

**3.8.2.6 Automated Call Distribution (ACD) System**

3.8.2.6.1 The CONTRACTOR shall install, operate and monitor an automated call distribution (ACD) system for the customer service telephone call center. The ACD system shall:

3.8.2.6.2 Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;

3.8.2.6.3 Transfer calls to other telephone lines;

3.8.2.6.4 Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;

3.8.2.6.5 Provide a message that notifies callers that the call may be monitored for quality control purposes;

3.8.2.6.6 Measure the number of calls in the queue at peak times;

3.8.2.6.7 Measure the length of time callers are on hold;

3.8.2.6.8 Measure the total number of calls and average calls handled per day/week/month;

3.8.2.6.9 Measure the average hours of use per day;

- 3.8.2.6.10 Assess the busiest times and days by number of calls;
- 3.8.2.6.11 Record calls to assess whether answered accurately;
- 3.8.2.6.12 Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines are not disrupted;
- 3.8.2.6.13 Provide interactive voice response (IVR) options that are user-friendly to members and include a decision tree illustrating the IVR system; and
- 3.8.2.6.14 Inform the member to dial 911 if there is an emergency.

### 3.8.3 Call Center Performance Standards

- 3.8.3.1 The CONTRACTOR shall maintain the following Call Center Performance Standards:
  - 3.8.3.1.1 An average of eighty percent (80%) of calls each month are answered within thirty (30) seconds or the call is directed to an automatic call pickup system with IVR options;
  - 3.8.3.1.2 The average response time shall equal Number of Calls Picked-up within thirty (30) seconds each month divided by the total calls received each month
  - 3.8.3.1.3 No more than two percent (2%) of incoming calls shall receive a busy signal per day;
  - 3.8.3.1.4 An average hold time of three (3) minutes or less;
  - 3.8.3.1.5 Hold time, or wait time includes:
    - 3.8.3.1.5.1 The time a caller spends waiting for assistance from a customer service representative after the caller has navigated the IVR system and requested a live person; and
    - 3.8.3.1.5.2 The measure of time when a customer service representative places a caller on hold.
  - 3.8.3.1.6 An abandoned rate of calls of not more than five (5) percent;
    - 3.8.3.1.6.1 The abandoned rate of calls equals the number of calls abandoned each month divided by the total calls received each month.
- 3.8.3.2 The CONTRACTOR must conduct ongoing quality assurance to ensure these standards are met.

- 3.8.3.3 Upon sixty (60) days' notice by the Department, the CONTRACTOR must use a generally accepted statistically valid sample survey at the end of each call that the Medicaid Managed Care Member may complete.
- 3.8.3.3.1 The CONTRACTOR will include survey questions developed by the Department and report on the survey results.
- 3.8.3.3.2 The results will be reported in accordance with procedures established in the Managed Care Policy and Procedure Manual.
- 3.8.3.4 If the Department determines it is necessary to conduct onsite monitoring of the CONTRACTOR's call center functions, the CONTRACTOR is responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring if the call center is located outside of the State.
- 3.8.3.5 The CONTRACTOR, including any subcontractor responsible for call center activity, shall have written policies regarding member rights and responsibilities.
- 3.8.3.6 The CONTRACTOR and its subcontractor shall comply with all applicable state and federal laws pertaining to member rights and privacy.
- 3.8.3.7 The CONTRACTOR and subcontractor shall further ensure that the CONTRACTOR's employees, CONTRACTORS and providers consider and respect those rights when providing services to members.

### **3.9 Member Handbook**

- 3.9.1 The CONTRACTOR shall provide each Medicaid Managed Care Member a Medicaid Managed Care Member handbook and other written materials as specified in this Section of this Contract. The CONTRACTOR's Medicaid Managed Care Member handbook must be updated as required during the term of this Contract, and the CONTRACTOR must document the changes on a change control log posted on its website. The CONTRACTOR shall develop and maintain a member handbook that adheres to the requirements in 42 CFR §438.10 (f)(6). The Member Handbook, and any subsequent changes thereto, must be submitted to the Department for review and approval. At a minimum, the member handbook shall include the following information:
- 3.9.1.1 Table of contents;
- 3.9.1.2 A general description about how the Medicaid Managed Care Organization operates, member rights and responsibilities, appropriate utilization of services including Emergency Room for non-emergent conditions, a description of the Primary Care Provider (PCP) selection process, and the Primary Care Provider's (PCP's) role as coordinator of services;
- 3.9.1.3 Member's right to disenroll from the CONTRACTOR;

- 3.9.1.4 Member's right to change providers within the CONTRACTOR;
- 3.9.1.5 Any restrictions on the member's freedom of choice among contracted providers;
- 3.9.1.6 Member's rights and protections, as specified in 42 CFR §438.100;
- 3.9.1.7 The amount, duration, and scope of benefits available to the member under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled;
- 3.9.1.8 Procedures for obtaining benefits, including prior authorization requirements;
- 3.9.1.9 Description of the purpose of the Medicaid card and the CONTRACTOR's Medicaid Managed Care Member ID card and why both are necessary and how to use them;
- 3.9.1.10 The extent to which, and how, members may obtain benefits, including family planning services from out-of-network providers;
- 3.9.1.11 The extent to which, and how, after-hours and emergency coverage are provided, including:
  - 3.9.1.11.1 What constitutes an emergency medical condition, emergency services, and post-stabilization services, as defined in 42 CFR §438.114(a);
  - 3.9.1.11.2 That prior authorization is not required for emergency services;
  - 3.9.1.11.3 The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent;
  - 3.9.1.11.4 The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services; and
  - 3.9.1.11.5 That, subject to the provisions of 42 CFR §438, the member has a right to use any hospital or other setting for emergency care.
- 3.9.1.12 The post-stabilization care services rules set forth in 42 CFR 422.113(c);
- 3.9.1.13 Policy on referrals for specialty care and other benefits not furnished by the member's PCP;
- 3.9.1.14 Cost sharing, if any;
- 3.9.1.15 How and where to access any benefits that are available under the Medicaid State Plan but are not covered by the CONTRACTOR, including any cost sharing;
- 3.9.1.16 How transportation is provided;

- 3.9.1.17 How and where to obtain counseling or referral services that the CONTRACTOR, or a provider under contract with the CONTRACTOR, does not cover because of moral or religious objections;
- 3.9.1.18 Member grievance, appeal and state fair hearing procedures and time frames, as described in 42 CFR §§438.400 through 438.424 and Section 9 of this Contract;
- 3.9.1.19 Grievance, appeal and fair hearing procedures that include the following for State Fair Hearing
- 3.9.1.19.1 The right to a hearing;
  - 3.9.1.19.2 The method for obtaining a hearing;
  - 3.9.1.19.3 The rules that govern representation at the hearing;
  - 3.9.1.19.4 The right to file grievances and appeals;
  - 3.9.1.19.5 The requirements and timeframes for filing a grievance or appeal;
  - 3.9.1.19.6 The availability of assistance in the filing process;
  - 3.9.1.19.7 The toll-free numbers that the member can use to file a grievance or an appeal by phone;
  - 3.9.1.19.8 The fact that, when requested by the member:
    - 3.9.1.19.8.1 Benefits will continue if the member files an appeal or a request for State Fair Hearing within the timeframes specified for filing; and
    - 3.9.1.19.8.2 The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.
  - 3.9.1.19.9 Medicaid Managed Care Members whose request for a disenrollment for good cause is not approved by the Department or its designee, may request a fair hearing of the decision.
- 3.9.1.20 Advance Directives, set forth in 42 CFR §438.6(i)(2) - A description of advance directives which shall include:
- 3.9.1.20.1 The CONTRACTOR's policies related to advance directives, which meet the requirements of 42 CFR § 489 SUBPART I;

- 3.9.1.20.2 The member's rights under State law, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to formulate advance directives; any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) calendar days after the effective date of the change;
- 3.9.1.20.3 Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.
- 3.9.1.20.4 Information that complaints concerning non-compliance with the advance directive requirements may be filed with the State survey and certification agency.
- 3.9.1.21 Information to call the Medicaid Customer Service Unit toll-free hotline or visit a local Medicaid eligibility office to report if family size, living arrangements, county of residence, or mailing address changes;
- 3.9.1.22 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";
- 3.9.1.23 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;
- 3.9.1.24 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;
- 3.9.1.25 Information about the requirement that a member shall notify the CONTRACTOR immediately of any Worker's Compensation claim, a pending personal injury or medical malpractice law suit, or if the member has been involved in an auto accident;
- 3.9.1.26 Reporting requirements for the member who has or obtains another health insurance policy, including employer-sponsored insurance. Such situations shall be reported to the CONTRACTOR;
- 3.9.1.27 Instructions on how to request interpretation and translation services when needed at no cost to the member. This instruction shall be included in all versions of the handbook;
- 3.9.1.28 Information on the member's right to a second opinion at no cost and how to obtain it;
- 3.9.1.29 Any additional services provided by the CONTRACTOR;
- 3.9.1.30 The date of the last revision;
- 3.9.1.31 Additional information that is available upon request, including the following:

3.9.1.31.1 Information on the structure and operation of the CONTRACTOR;

3.9.1.31.2 Physician incentive plans [42 CFR 438.6(h)]; and

3.9.1.31.3 Service utilization policies.

### **3.10 Provider Directory**

3.10.1 The CONTRACTOR shall make available a provider directory to all Medicaid Managed Care Members. The provider directory shall be made available by the CONTRACTOR via internet and phone.

3.10.2 The provider directory shall include the names, locations, office hours, age groups, telephone numbers of, and non-English languages spoken by current CONTRACTOR providers.

3.10.2.1 The provider directory shall include, at a minimum, information relating to PCPs, specialists, pharmacies, hospitals, certified nurse midwives and licensed midwives, and ancillary providers.

3.10.2.2 The provider directory also shall identify providers that are not accepting new patients.

3.10.3 The CONTRACTOR shall maintain an online provider directory containing all the information described above in this Section of this Contract.

3.10.3.1 The CONTRACTOR shall update the online provider directory at least monthly.

3.10.3.2 The CONTRACTOR shall file an attestation to this effect with the department each month, even if no changes have occurred.

3.10.4 In accordance with s. 1932(b)(3)(B) of the Social Security Act, the provider directory shall include a statement that some providers may choose not to perform certain services based on religious or moral beliefs.

3.10.5 The CONTRACTOR shall arrange the provider directory as follows:

3.10.5.1 Providers listed by name in alphabetical order, showing the provider's specialty;

3.10.5.2 Providers listed by specialty, in alphabetical order;

3.10.6 The CONTRACTOR shall have procedures to inform potential enrollees and Medicaid Managed Care Members, upon request, of any changes to service delivery and/or the provider network including the following:

3.10.6.1 Up-to-date information about any restrictions on access to providers, including providers who are not taking new patients;

- 3.10.6.2 An explanation to all potential enrollees that an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs;

### **3.11 Billing and Reconciliation**

- 3.11.1 If the CONTRACTOR desires a reconciliation of the enrollment, re-enrollment, and disenrollment data received from the Department, the CONTRACTOR must notify the Department within thirty (30) days of receipt of the enrollment file. If the Department agrees that reconciliation is necessary, the Department shall be responsible for said reconciliation.

### **3.12 Member Education**

- 3.12.1 The CONTRACTOR shall educate by written documentation or oral language to all Medicaid Managed Care Members in the initial mailing to the member regarding the appropriate utilization of Medicaid services. Please refer to Section 4 of this Contract for more information regarding Medicaid services.
- 3.12.2 Such education shall be provided no later than fourteen (14) calendar days from the CONTRACTOR's receipt of enrollment data from the Department, or its designee, and as needed thereafter.
- 3.12.3 The CONTRACTOR shall identify and educate Medicaid Managed Care Members who access the system inappropriately and provide continuing education as needed.
- 3.12.4 The CONTRACTOR shall be responsible for reminding pregnant Medicaid Managed Care Members that their newborns will be automatically enrolled for the birth month and that the Medicaid Managed Care Member may choose to enroll the Newborn in another CONTRACTOR's Health Plan after delivery by contacting South Carolina Healthy Connections Choices.
- 3.12.5 The CONTRACTOR shall ensure that where at least five percent (5%) or more of the resident population of a county is non-English speaking and speaks a specific foreign language, materials will be made available in that specific language to assure a reasonable chance for all Medicaid Managed Care Members to understand how to access the CONTRACTOR and use services appropriately.
- 3.12.6 The CONTRACTOR shall have written policies and procedures for educating Medicaid Managed Care Members about their benefits.
- 3.12.6.1 Member Education is defined as educational activities and materials directed at enrollees of a CONTRACTOR's Health Plan that increases the awareness, and favorably influences the attitudes and knowledge relating to the improvement of health on a personal or community basis.

3.12.6.2 Medicaid Managed Care Member education also includes information and materials that inform the Medicaid Managed Care Member on the CONTRACTOR's Policies, procedures, requirements and practices.

3.12.6.3 Further guidance on Member Education materials and activities can be found in the Department's Managed Care Policy and Procedure Guide.

3.12.7 The CONTRACTOR shall coordinate with the Department or its designee on Medicaid Managed Care Member education activities as outlined in the Managed Care Policy and Procedure Manual to meet the health care educational needs of the Medicaid Managed Care Members.

3.12.8 The CONTRACTOR shall not discriminate against Medicaid Managed Care Members on the basis of their health history, health status or need for health care services.

3.12.8.1 This applies to enrollment, re-enrollment or disenrollment from the CONTRACTOR's Health Plan.

### **3.13 Member Communication**

3.13.1 The following guidelines apply to written materials and oral communication with Medicaid Managed Care Members. The guidelines will apply to the CONTRACTOR and any subcontractor.

#### **3.13.1.1 Written Materials Guidelines**

3.13.1.1.1 The CONTRACTOR shall comply with 42 CFR § 438.10(c) as outlined in this Section of this Contract, as it relates to all written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.):

3.13.1.1.2 All member materials must be in a style and reading level that will accommodate the reading skills of Medicaid Managed Care Members. In general the writing should be at no higher than a 6th grade level, as determined by any one of the indices below, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy:

- Flesch – Kincaid;
- Fry Readability Index;
- PROSE The Readability Analyst (software developed by Educational Activities, Inc.);
- Gunning FOG Index;
- McLaughlin SMOG Index

3.13.1.1.3 All written materials must be clearly legible with a minimum font size of twelve-point, with the exception of Member ID cards, and unless otherwise approved by Department.

3.13.1.1.4 The CONTRACTOR's name, mailing address (and physical location, if different) and toll-free number must be prominently displayed on the cover of all multi-page marketing materials.

3.13.1.1.5 All multi-page written member materials must notify the member that real-time oral interpretation is available for any language at no expense to them, and how to access those services;

3.13.1.1.6 No person or CONTRACTOR may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems the words "Medicaid," or "Department of Health and Human Service," except as permitted by the Department when prior written approval is obtained. Specific written authorization from the Department is required to reproduce, reprint, or distribute any Agency form, application, or publication for a fee. A disclaimer that accompanies the inappropriate use of program or Department terms does not provide a defense. Each piece of mail or information constitutes a violation.

### **3.13.1.2 Translation Services and Alternative Formats**

3.13.1.2.1 The CONTRACTOR shall develop written policies and procedures for providing language interpreter and translation services to any member who needs such services, including but not limited to, members with limited English proficiency and members who are hearing impaired in accordance with 42 CFR 438.10.

3.13.1.2.2 The CONTRACTOR shall provide interpreter and translation services free of charge to members.

3.13.1.2.3 Interpreter services shall be available in the form of in-person interpreters, sign language or access to telephonic assistance, such as the ATT universal line.

3.13.1.2.4. The CONTRACTOR shall make all written materials available in alternative formats and in a manner that takes into consideration the enrollee's special needs, including those who are visually impaired or have limited reading proficiency. The CONTRACTOR shall notify all enrollees and, upon request, potential enrollees that information is available in alternative formats and how to access those formats.

### **3.13.1.3 Provider-to-Enrollee Communication**

3.13.1.3.1 An MCO, PIHP, or PAHP may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an enrollee who is a patient:

- for the enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
- for any information the enrollee needs in order to decide among all relevant treatment options.
- for the risks, benefits, and consequences of treatment or non-treatment.
- for the enrollee's right to participate in decisions regarding health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

### **3.13.2 Cultural Competency**

3.13.2.1 As required by 42 CFR §438.206, the CONTRACTOR shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Medicaid Managed Care Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

## **3.14 Enrollment and Disenrollment Process**

### **3.14.1 Medicaid Managed Care Member Identification Card**

3.14.1.1 The CONTRACTOR shall issue a Member identification (ID) card by the fifteenth (15<sup>th</sup>) day of the month in which the Member is enrolled in the CONTRACTOR's plan.

3.14.1.2 The CONTRACTOR must use the Medicaid Member's Identification Number issued by the Department.

3.14.1.3 Medicaid Managed Care Member ID cards must contain the following information:

3.14.1.3.1 CONTRACTOR name and address

3.14.1.3.2 Primary care provider practice name

3.14.1.3.3 Medicaid Managed Care Member name and Medicaid identification number

3.14.1.3.4 Expiration date (optional)

3.14.1.3.5 Toll-free telephone numbers, including the number a Medicaid Managed Care Member may use in urgent or emergency situations or to obtain any other information.

3.14.1.3.6 SC Healthy Connections logo, which must be in color.

3.14.1.4 The CONTRACTOR shall reissue the Medicaid Member ID card within fourteen (14) calendar days after notice by a member of a lost card, a change in the member's PCP, or for any other reason that results in a change to the information on the member ID card.

3.14.1.5 The holder of the member identification card issued by the CONTRACTOR shall be a Medicaid Managed Care Member or guardian of the Medicaid Managed Care Member.

3.14.1.6 If the CONTRACTOR has knowledge of any Medicaid Managed Care Member permitting the use of this identification card by any other person, the CONTRACTOR shall immediately report this violation to the Department.

3.14.1.7 To ensure immediate access to services, the CONTRACTOR shall establish appropriate mechanisms, procedures and Policies to identify its Medicaid Managed Care Members to Providers until the Medicaid Managed Care Member receives the MCO ID card from the CONTRACTOR.

3.14.1.8 The CONTRACTOR shall also ensure that its Subcontractor's/network Providers can identify Medicaid Managed Care Members, in a manner that will not result in discrimination against the Medicaid Managed Care Members, in order to provide or coordinate the provision of all Core Benefits and/or Additional Services and Out-of-Network Services.

3.14.2 **Member's Rights and Responsibilities**

3.14.2.1 The CONTRACTOR shall make available to Medicaid Managed Care Members both oral and written information about the nature and extent of their rights and responsibilities as Medicaid Managed Care Members of the CONTRACTOR.

3.14.2.2 **Member Rights**

Every Medicaid Managed Care Member is guaranteed the following rights:

- 3.14.2.2.1 To be treated with respect and with due consideration for dignity and privacy;
- 3.14.2.2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand and participate in decisions regarding healthcare, including the right to refuse treatment;
- 3.14.2.2.3 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; and
- 3.14.2.2.4 To be able to request and receive a copy of the member's medical records, and request that they be amended or corrected as specified in 45 CFR §164.
- 3.14.2.2.5 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the CONTRACTOR and its providers or the Department treat the Medicaid Managed Care Member.

#### 3.14.2.3 Member Responsibilities

The Medicaid Managed Care Member's responsibilities shall include, but are not limited to:

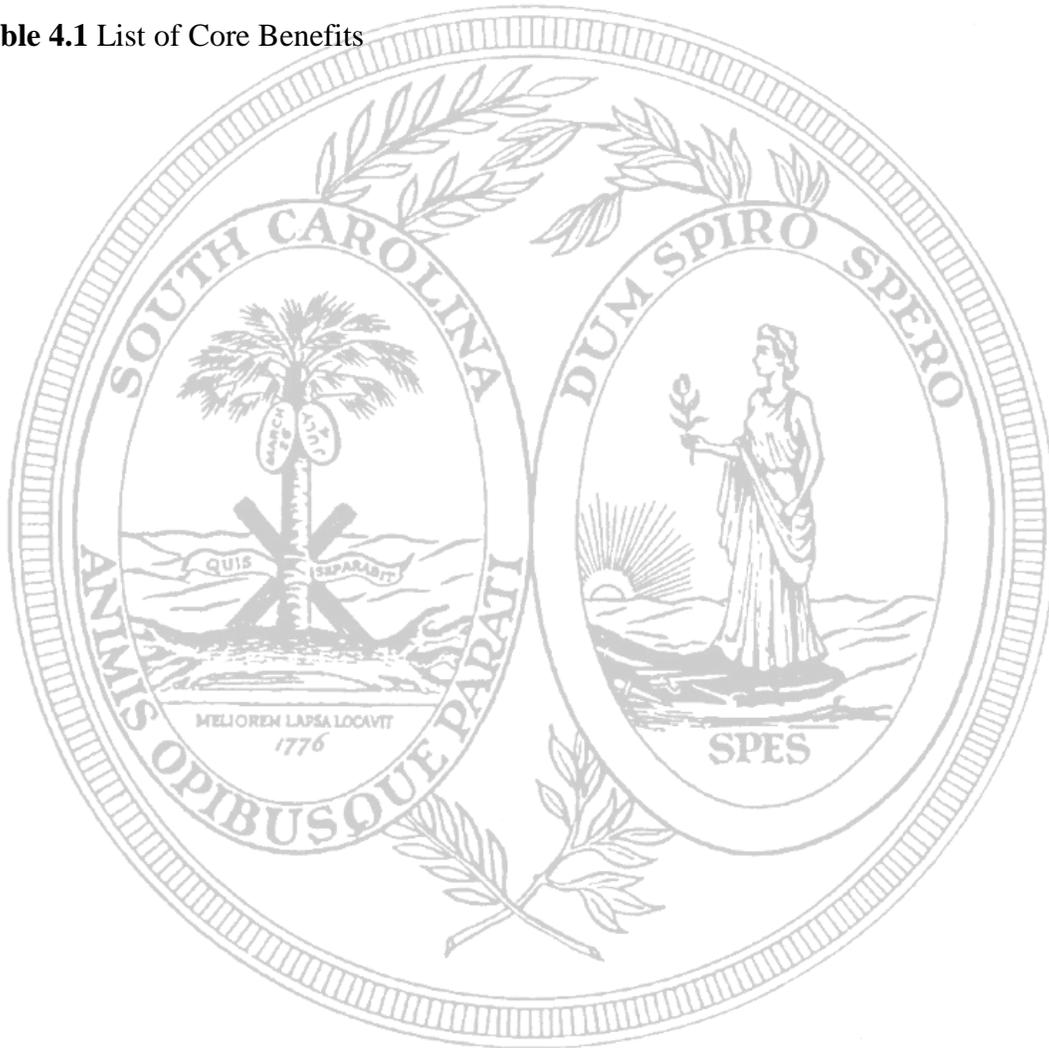
- 3.14.2.3.1 Inform the CONTRACTOR of the loss or theft of ID cards;
- 3.14.2.3.2 Present ID cards when using health care services;
- 3.14.2.3.3 Be familiar with the CONTRACTOR's Health Plan procedures to the best of their abilities;
- 3.14.2.3.4 Call or contact the CONTRACTOR to obtain information and have questions clarified;
- 3.14.2.3.5 Provide participating network providers with accurate and complete medical information;
- 3.14.2.3.6 Follow the prescribed course of care recommended by the provider or let the provider know the reasons the treatment cannot be followed, as soon as possible;
- 3.14.2.3.7 Make every effort to keep a scheduled appointment or cancel an appointment in advance of when it is scheduled.

## **4 SERVICES**

### **4.1 Core Benefits for the South Carolina Medicaid Managed Care Program**

- 4.1.1 The CONTRACTOR shall cover the physical health and behavioral health services outlined within this Section of this Contract.
- 4.1.2 Core Benefits shall be available to each Medicaid Managed Care Member within the CONTRACTOR's service area. The CONTRACTOR shall provide Core Benefits and services to Medicaid Managed Care Members, as illustrated in Table 4.1.

**Table 4.1** List of Core Benefits



<b>CORE BENEFITS</b>
Ambulance Transportation
Ancillary Medical Services
Audiological Services
Chiropractic Services
Communicable Disease Services
Disease Management
Durable Medical Equipment
Early & Periodic Screening, Diagnosis and Treatment (EPSDT) / Well Child
Family Planning Services
Hearing Aids and Hearing Aid Accessories
Home Health Services
Hysterectomies, Sterilizations, and Abortions (as covered in policy guidelines)
Independent Laboratory and X-Ray Services
Inpatient Hospital Services
Institutional Long-Term Care Facilities / Nursing Homes for short-term stays
Maternity Services
Newborn Hearing Screenings
Outpatient Pediatric AIDS Clinic Services (OPAC)
Outpatient Services
Physician Services
Prescription Drugs
Preventive and Rehabilitative Services for Primary Care Enhancement (PSPCE/RSPCE)
Psychiatric Services
Rehabilitative Therapies for Children – Non-Hospital Based
Substance Abuse
Transplant and Transplant-Related Services
Vision Care Services
Notes:
<ul style="list-style-type: none"> <li>Detailed benefit coverage information for all Core Benefits listed within this Table can be found within the Managed Care Policy and Procedure Manual.</li> </ul>

4.1.3 The CONTRACTOR shall coordinate the delivery of physical health, behavioral health and long-term care services.

- 4.1.4 Core benefits shall be furnished in accordance with medical necessity and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries up to the limits as specified in the Medicaid fee-for-service program as defined in the State Plan, administrative rule and Department policy, procedure manuals and all applicable federal and state statutes, rule, and regulations.
- 4.1.5 In the event the amount, duration and/or scope of services is modified under the Medicaid fee-for-service program, the CONTRACTOR is required to follow the modified version unless otherwise exempted by the Department.
- 4.1.6 The CONTRACTOR will honor and pay for core benefits for new Medicaid Managed Care Members or when a new benefit is added as a core benefit.

## **4.2 Service Limits**

- 4.2.1 In Accordance with 42 CFR 438.2010(a)(3), the CONTRACTOR:
- 4.2.1.1 Shall ensure that services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished;
- 4.2.1.2 May not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the Medicaid Managed Care Member;
- 4.2.1.3 May place appropriate limits on a service:
- 4.2.1.3.1 On the basis of certain criteria, such as medical necessity; or
- 4.2.1.3.2 For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.
- 4.2.2 The CONTRACTOR may exceed the service limits as specified in the State Plan. Such services are not eligible for reimbursement by the Department.

## **4.3 Out-of-Network Coverage**

- 4.3.1 The CONTRACTOR shall provide or arrange for out-of-network coverage of core benefits in emergency situations and non-emergency situations—when service cannot be provided by an In-Network Provider in the required timeframe and in accordance with Section 6 of this Contract.

## **4.4 Second Opinions**

- 4.4.1 The CONTRACTOR shall provide for a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by a member, parent and/or legally appointed representative.

- 4.4.2 The second opinion shall be provided by a contracted qualified health care professional, or the CONTRACTOR shall arrange for a member to obtain one from a non-contract provider when a qualified provider is not available in network.
- 4.4.3 The second opinion shall be provided at no cost to the member.

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

- 4.5.1 The CONTRACTOR shall have written procedures for notification, tracking, and follow-up to ensure Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services will be available to all eligible Medicaid Managed Care Program children and young adults.
- 4.5.2 The EPSDT program consists of two mutually supportive, operational components:
- 4.5.2.1 Assuring the availability and accessibility of required healthcare services; and
  - 4.5.2.2 Helping the Medicaid beneficiary and the parents or guardians use these resources effectively.
- 4.5.3 The requirements for provision of EPSDT services are outlined in the Managed Care Policy and Procedure Manual.
- 4.5.4 The CONTRACTOR shall assure that all medically necessary, Medicaid-covered diagnosis, treatment services and screenings are provided, either directly, through subcontracting, or by referral.
- 4.5.4.1 The utilization of these services shall be reported as referenced in the Managed Care Policy and Procedure Manual.
  - 4.5.4.2 Expenditures for the medical services as previously described have been factored into the capitation payment described in Appendix B of this Contract, and the CONTRACTOR will not receive any additional payments related to these EPSDT services.

#### **4.6 Emergency Medical Services**

The CONTRACTOR shall provide emergency and post-stabilization services as specified below.

- 4.6.1 The CONTRACTOR will provide emergency services rendered without the requirement of prior authorization of any kind
- 4.6.2 The CONTRACTOR shall advise all Medicaid Managed Care Members of the provisions governing in- and out-of-service-area use of emergency services.

- 4.6.3 Consistent with federal requirements under 42 CFR 438.206 the CONTRACTOR shall monitor emergency service utilization (by both provider and member) and shall have guidelines for implementing corrective action for inappropriate utilization.
- 4.6.4 For utilization review, the test for appropriateness of the request for emergency services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this Contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.
- 4.6.5 The CONTRACTOR shall not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.
- 4.6.6 The CONTRACTOR shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Medicaid Managed Care Member's PCP, MCO or applicable state entity of the Medicaid Managed Care Member's screening and treatment within ten (10) calendar days of presentation for emergency services.
- 4.6.7 The CONTRACTOR shall not deny payment for treatment when a representative of the entity instructs the Medicaid Managed Care Member to seek emergency services.
- 4.6.8 The CONTRACTOR shall not deny payment for treatment obtained when a Medicaid Managed Care Member had an emergency medical condition and the absence of immediate medical attention would have had the outcomes specified in 42 CFR 438.114(a) of the definition of Emergency Medical Condition.
- 4.6.9 The CONTRACTOR must cover and pay for emergency services regardless of whether the provider that furnishes the service has a contract with the CONTRACTOR consistent with 42 CFR 438.114.
- 4.6.10 The CONTRACTOR shall make prompt payment for covered emergency services furnished by providers that have no arrangements with the CONTRACTOR for the provision of such services. The CONTRACTOR shall defer to the attending emergency physician or the provider actually treating the Medicaid Managed Care Member for the determination of when the Medicaid Managed Care Member is sufficiently stabilized for transfer or discharge.
- 4.6.11 A Medicaid Managed Care Member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- 4.6.12 **Post-Stabilization Services**

4.6.12.1 The CONTRACTOR shall be responsible for payment to providers in and out of the network service area, without requiring prior approval, for the following services and in accordance with the Social Security Act, Section 1867 (42 U.S.C. 1395 dd):

4.6.12.1.1 Determining if an emergency exists for Medicaid Managed Care Members when the medical screening service is performed.

4.6.12.1.2 Treatment as may be required to stabilize the medical condition as specified in Section 4 of this Contract.

4.6.12.1.3 Transfer of the individual to another medical facility within Social Security Act Section 1867 (42 U.S.C. 1395 dd) guidelines and other applicable state and federal regulations.

4.6.12.2 The CONTRACTOR shall cover services subsequent to stabilization:

4.6.12.2.1 That were pre-approved by the CONTRACTOR,

4.6.12.2.2 That were not pre-approved by the CONTRACTOR because the CONTRACTOR did not respond to the provider of post-stabilization care services request for pre-approval within one (1) hour after the request was made,

4.6.12.2.3 If the CONTRACTOR could not be contacted for pre-approval,

4.6.12.2.4 If the CONTRACTOR and the treating physician cannot reach an agreement concerning the Medicaid Managed Care Member's care and a network physician is not available for consultation. In this situation, the CONTRACTOR shall give the treating physician the opportunity to consult with a network physician, and the treating physician may continue with the care of the member until a network physician is reached or one of the criteria of 42 CFR 422.113(c)(3) is met.

4.6.12.3 Expenditures for the medical services as previously described in this Section of this Contract have been factored into the Capitation Payment described in Appendix B of this Contract, and the CONTRACTOR will not receive any additional payments.

4.6.12.4 The CONTRACTOR shall limit charges to Medicaid Managed Care Members for any post-stabilization care services to an amount no greater than what the CONTRACTOR would charge if the Medicaid Managed Care Member had obtained the services through one of the CONTRACTOR's providers.

4.6.12.5 The CONTRACTOR's financial responsibility for post-stabilization care services it has not pre-approved ends when

4.6.12.5.1 A network physician with privileges at the treating hospital assumes responsibility for the Medicaid Managed Care Member's care,

4.6.12.5.2 A network physician assumes responsibility for the Medicaid Managed Care Member's care through transfer,

4.6.12.5.3 A representative of the CONTRACTOR and the treating physician reach an agreement concerning the Medicaid Managed Care Member's care, or

4.6.12.5.4 The Medicaid Managed Care Member is discharged.

#### **4.7 Pharmacy / Prescription Drugs**

4.7.1 The CONTRACTOR may implement a preferred drug list (PDL) to encourage the use of the most cost-effective medication within a drug class. The PDL must be approved by the CONTRACTOR's Pharmacy & Therapeutics (P&T) Committee prior to implementation. The current PDL shall be provided to the Department upon execution of the Contract and any negative PDL changes shall be communicated to the Department prior to implementation. Negative PDL changes must be communicated to affected beneficiaries at least thirty (30) days prior to implementation. While the CONTRACTOR may employ a PDL and other mechanisms to promote cost-effective, clinically appropriate medication utilization, all FDA-approved medications must ultimately be covered except for those listed in the Managed Care Policy and Procedure Manual.

4.7.2 The CONTRACTOR shall support and use the Universal PA Medication form implemented October 1, 2012 in accordance with the Managed Care Policy and Procedure Manual.

4.7.3 For drugs subject to a prior authorization, in an emergency situation, the CONTRACTOR shall authorize the pharmacist to issue a five (5) day supply to the Medicaid Managed Care Member.

4.7.4 Information regarding coverage allowance for a non-formulary product shall be disseminated to Medicaid Managed Care Members in the Medicaid Managed Care Member's Handbook and to providers in the CONTRACTOR's Provider Manual.

4.7.5 If the CONTRACTOR requires that certain medications be obtained from a central "specialty pharmacy", a mechanism must be available to allow the initial supply to be provided via a local pharmacy from which the medication is available if the medical circumstances require more immediate access than is available from the specialty pharmacy.

4.7.6 If there is a dispute between the Department and the drug manufacturer regarding federal drug rebates, the CONTRACTOR shall assist the Department in dispute resolution by providing information regarding claims and provider details. Failure to collect drug rebates due to the CONTRACTOR's failure to assist the Department will result in the Department's recouping from the CONTRACTOR any determined uncollected rebates.

4.7.7 **Pharmacy Lock-in Program**

4.7.7.1 The CONTRACTOR will implement a Member Pharmacy Lock-in Program and other methods to monitor Members' use of prescription drugs based on policies and Member selection criteria established by the Department and promulgated in the Managed Care Policy & Procedures Guidelines.

4.7.7.2 The CONTRACTOR may lock-in additional Members based on a medical review or clinical criteria above and beyond that established by the Department.

4.7.7.3 The Department will develop and publish statewide criteria for screening eligible Members as candidates for selection for the pharmacy lock-in program.

4.7.7.4 The Department will run quarterly utilization profiles on all Medicaid beneficiaries based on the published statewide criteria. The Department will refer the members selected as eligible lock-in candidates to their respective MCOs for pharmacy lock-in.

4.7.7.5 Once the Department identifies Members eligible for the Pharmacy Lock-in Program to the CONTRACTOR, the CONTRACTOR shall conduct a second review to identify any Members that should not be in the program due to complex drug therapy or other case management needs.

4.7.7.6 The CONTRACTOR shall have a process at the point-of-sale to "lock-in" the member to the chosen pharmacy, therefore denying claims from pharmacy providers other than the designated pharmacy.

4.7.7.7 Members identified as eligible lock-in candidates shall be allowed to choose their primary pharmacy provider.

4.7.7.8 The CONTRACTOR must be able to make an exception in cases of an emergency and be able to allow for a five (5) day emergency supply of medication to be filled by a pharmacy other than the designated lock-in pharmacy. Such emergency supply shall be permitted to assure the provision of necessary medication required in an interim/urgent basis when the assigned pharmacy does not immediately have the medication prescribed, or when a new prescription is medically needed at a time when the assigned pharmacy is closed.

- 4.7.7.9 The CONTRACTOR shall facilitate an appeal process for the Member to appeal the lock-in selection, in accordance with the requirements in Section 9 of this Contract. If a Member does appeal selection for the lock-in, the CONTRACTOR cannot implement the member pharmacy restrictions until the appeal process has run its course.
- 4.7.7.10 The CONTRACTOR will follow the timeline established in the Managed Care Policy and Procedures Manual for member notification and the appeals process, but must be able to restrict the member to the chosen pharmacy no later than ninety (90) days after referral from the Department, if the member does not file an appeal. This provision notwithstanding, the CONTRACTOR shall be allowed one hundred and eighty (180) days from the effective date of this contract to lock in the initial list of members referred by the Department.
- 4.7.7.11 The Department shall provide CONTRACTOR with templates for letters to the Member assigned pharmacy that describe the program and reason for restriction. Any and all modifications must be approved by the Department prior to distribution.
- 4.7.7.12 The CONTRACTOR will be responsible for all notification to members and providers. The member notification letter must be sent through Certified Mail at least thirty (30) days prior to the Effective Lock In Date, and include the following:
- 4.7.7.12.1 A pre-selected pharmacy for the member.
  - 4.7.7.12.2 Instructions and a deadline if the member opts to choose a different pharmacy; and
  - 4.7.7.12.3 How to file an appeal.
- 4.7.7.13 The CONTRACTOR must submit monthly and quarterly reports on pharmacy lock-in participants in accordance with specifications established by the Department in the Policy & Procedures Guidelines.
- 4.7.7.14 In addition, the CONTRACTOR will report cost savings and any decreases in inappropriate utilization that result from the lock-in. A standard methodology for determining cost savings will be developed by the Department and provided to the CONTRACTOR.
- 4.7.7.15 The CONTRACTOR shall submit policies and procedures for how it will provide care management and education reinforcement of appropriate medication/pharmacy use to participants in the pharmacy lock-in program. These policies and procedures shall include a process to coordinate with primary care providers and potential DAODAS programs within the member's county of residence, and shall further provide that Medicaid Managed Care Members receive any needed referrals for counseling, substance abuse, or other services.

4.7.7.16 The lock-in period must be for a minimum of two years from the date the Member's restriction begins. The CONTRACTOR's policies and procedures shall provide for periodic evaluation of the continued need for lock-in for each Medicaid Managed Care Member in the program. Such periodic evaluation shall occur at least annually.

4.7.7.17 If a Member in the pharmacy lock-in program changes Managed Care plans, the CONTRACTOR of the first plan must send in the Member's health history, including any prescription drugs utilization profiles and the education and care management plan to the Department. The Department will then send that information to the second managed care CONTRACTOR. After enrollment in the second plan, that CONTRACTOR must continue the lock-in program for that member until the completion of the initial two years.

#### **4.8 Hysterectomies**

4.8.1 The CONTRACTOR shall cover the cost of hysterectomies when they are non-elective and medically necessary as provided in 42 CFR §441.255 (2010, as amended). Non-elective, medically necessary hysterectomies shall meet the requirements as outlined in the Managed Care Policy and Procedure Manual. Expenditures for the medical services as previously described in this Section of this Contract have been factored into the Capitation Payment described in Appendix B of this Contract, and the CONTRACTOR will not receive any additional payments for these services.

#### **4.9 Sterilization**

4.9.1 The CONTRACTOR shall provide sterilization services in accordance with 42 CFR 441 Subpart F. Sterilization for a male or female must also meet the requirements as outlined in the Managed Care Policy and Procedure Manual. Expenditures for the medical services described in this Section of this Contract have been factored into the Capitation Payment described in Appendix B of this Contract, and the CONTRACTOR will not receive any additional payment for these services.

#### **4.10 Limitations of Abortions**

4.10.1 The CONTRACTOR shall perform abortions in accordance with 42 CFR 441, Subpart E and the requirements of the Hyde Amendment (Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act, 1998, Public Law 105-78, §§ 509 and 510). The CONTRACTOR will be reimbursed for abortion services only if performed in accordance with these provisions. Abortions must be documented with a completed Abortion Statement Form and must meet the requirements as outlined in the Managed Care Policy and Procedure Manual to satisfy state and federal regulations.

4.10.2 The CONTRACTOR understands and agrees that the Department shall not make payment to the CONTRACTOR for any health benefits coverage under this Contract if any abortion performed hereunder violates federal law or regulations. For the purposes of this Section of this Contract, “health benefits coverage” shall mean the package of services covered by the CONTRACTOR pursuant to a contract or other arrangement.

#### **4.11 Medical Services for Special Populations**

4.11.1 The CONTRACTOR shall implement mechanisms to assess each Medicaid Managed Care Member identified by the Department and identified to the CONTRACTOR by the Department as having special health care needs in order to identify any ongoing special condition of the Medicaid Managed Care Member that requires a course of treatment or regular care monitoring. The assessment mechanism must use appropriate Health Care Professionals. The CONTRACTOR must have a mechanism in place to allow Medicaid Managed Care Members to directly access a specialist as appropriate for the member’s condition and identified needs (for example, through the standard referral or an approved number of visits). The special populations are identified as individuals that may require additional health care services that should be incorporated into a health management plan that guarantees that the most appropriate level of care is provided for these individuals.

4.11.2 The CONTRACTOR shall determine the need for any enhanced services that may be necessary for these populations to maintain their health and wellbeing. The Managed Care Policy and Procedure Manual outlines the best practices and procedures that the State Plan uses to serve the designated special populations.

4.11.3 Expenditures for the health care services of the special populations as previously described in this Section of this Contract have been factored into the Capitation Payment described in Appendix B of this Contract and the CONTRACTOR will not receive any additional payments for these services.

#### **4.12 Targeted Case Management (TCM) Services**

4.12.1 While the CONTRACTOR is not responsible for covering Targeted Case Management (TCM) services, the CONTRACTOR shall be responsible for developing a system for coordinating health care for Medicaid Managed Care Members that require TCM services that avoids duplication and ensures that the Medicaid Managed Care Member’s needs are adequately met. This requires that the CONTRACTOR and the case management agency develop a system for exchanging information.

4.12.2 TCM services are those services that will assist an individual eligible under the State Plan in gaining access to needed medical, social, educational and other services to include a systematic referral process to the service with documented follow-up.

4.12.3 TCM services are available to alcohol and substance abuse individuals, children in foster care, chronically mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with mental retardation or a related disability, individuals with head or spinal cord injury or a related disability, children and adults with sickle cell disease and adults in need of protective services. Patients who are dually diagnosed with complex social and medical problems may require TCM services from more than one case management provider. A systematic referral process to providers for medical education, legal and rehabilitation services with documented follow up to ensure that the necessary services are available and accessible for each eligible patient is required.

4.12.4 The Department will be financially responsible for TCM programs.

### **4.13 School-Based Services**

4.13.1 School-based services are those Medicaid services provided in school districts to Medicaid-eligible children under the age of 21 years. Medicaid providers of these services will be reimbursed by the Department for these services.

4.13.2 The CONTRACTOR shall at a minimum have written procedures for promptly transferring medical and developmental data needed for coordinating ongoing care with school-based services.

### **4.14 Institutional Long-Term Care (LTC) Facilities/Nursing Facilities (NFs)**

4.14.1 The CONTRACTOR is responsible for reimbursing long-term-care facilities/nursing homes/hospitals that provide swing beds or administrative days for the first ninety (90) continuous days of service in a long-term-care/nursing home placement as specified in the Managed Care Policy and Procedure Manual. At the end of the ninety (90) day period, the Member can be disenrolled from the CONTRACTOR's plan at the earliest effective date allowed by system edits.

4.14.2 The CONTRACTOR is responsible for notifying the Department of any Medicaid Managed Care Members requiring institutionalization in a long-term-care facility/nursing home. The CONTRACTOR shall notify the Department or its designee when a Medicaid Managed Care Member is accepted and approved for institutionalization in a long term care facility/nursing home and again at the time the ninety (90) continuous days of placement is completed

4.14.3 All costs associated with long-term-care facilities/nursing homes/hospitals that provide swing beds or administrative days as previously described in this Section of this Contract have been factored into the Capitation Payment described in Appendix B of this Contract, and the CONTRACTOR will not receive any additional payments for these services.

#### **4.15 Behavioral Health Services**

4.15.1 The following treatment services will be reimbursed by the Department on a fee-for-service basis; all other psychiatric services not listed below will be provided by the CONTRACTOR:

4.15.1.1 Hospital Services provided at a psychiatric hospital in accordance with Managed Care Policy and Procedure Manual

4.15.1.2 Services provided by the Department of Mental Health (DMH).

4.15.1.3 At a future date within this contract period, the Department will carve-in all behavioral health services, and all Medicaid Managed Care Organizations (MCOs) will be required to contract with a single behavioral health organization (BHO), to be chosen by the Department.

#### **4.16 Communicable Disease Services**

4.16.1 The CONTRACTOR shall provide to Medicaid Managed Care Members communicable disease services. These services include those available to help control and prevent diseases such as:

4.16.1.1 Tuberculosis (TB),

4.16.1.2 Sexually transmitted diseases (STDs), and

4.16.1.3 Human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) infection, as specified in the Managed Care Policy and Procedure Manual.

4.16.2 The CONTRACTOR and/or its network provider for clinical management, treatment and direct observed therapy must refer suspected and actual TB cases to DHEC. DHEC provides a range of primary and secondary prevention services through its local health clinics to provide and/or coordinate communicable disease control services. This care will be coordinated with the CONTRACTOR's PCP.

#### **4.17 Member Incentives**

4.17.1 The CONTRACTOR may offer incentives to encourage a Medicaid Managed Care Member to change or modify behaviors or meet certain goals.

4.17.2 The CONTRACTOR shall prepare a description of the incentive(s) it seeks to offer and submit it to the Department for approval. The Department will review these proposals based on the policies set forth in the Department's Managed Care Policy and Procedure Manual.

4.17.3 Upon approval by the Department, incentives shall be included and incorporated as a part of the Contract and included in the CONTRACTOR's Medicaid Managed Care Member materials.

- 4.17.4 The Department will not provide any additional payment or reimbursement for member incentives.
- 4.17.5 When transportation is part of these incentives, it will be the responsibility of the CONTRACTOR.
- 4.17.6 If the CONTRACTOR seeks to discontinue or modify an incentive, it must notify the Department of any changes and receive approval for any modifications based on the schedule defined in the Department's current Managed Care Policy and Procedure manual.
- 4.17.7 The CONTRACTOR must continue to offer the incentive until the Department has approved the request to modify or discontinue the incentive.
- 4.17.8 Any cost, charges or expenses incurred by the Department or its designee including but not limited to changes to the website grids, member and provider notifications or any other related requirements are the responsibility of and will be paid by the CONTRACTOR.

#### **4.18 Additional Services**

- 4.18.1 The CONTRACTOR may offer additional services to enrolled Medicaid Managed Care Members. These additional services are health care services that are not covered by the South Carolina State Plan for Medical Assistance and/or are in excess of the amount, duration, and scope of those listed in the Managed Care Policy and Procedure Manual and Handbooks.
- 4.18.2 The Department will not provide any additional reimbursement for these additional services.
- 4.18.3 Transportation for these additional services is the responsibility of the Medicaid Managed Care Member and/or CONTRACTOR.
- 4.18.4 The CONTRACTOR shall provide the Department with a description of the additional services being considered by the CONTRACTOR for approval prior to offering such services.
- 4.18.5 If the CONTRACTOR seeks to discontinue or modify an additional service, it must notify the Department prior to the discontinuation of the service.
- 4.18.6 All changes must be submitted in time to change the benefit grid to coincide with the deletions or modification of any of the additional services, in accordance with requirements listed in the Managed Care Policy and Procedure Manual.
- 4.18.7 Once approved by the Department, the CONTRACTOR must notify its current Medicaid Managed Care Members at least thirty (30) days prior to discontinuation of or modification to the approved additional services made during the Contract year.

4.18.8 Any cost, charges or expenses incurred by the Department or its designee, including but not limited to changes to the website grids, member and provider notifications or any other related requirements, are the responsibility of and will be paid by the CONTRACTOR.

#### **4.19 Excluded Services**

4.19.1 Excluded services shall be defined as those services that members may obtain under the South Carolina State Plan but for which the CONTRACTOR is not financially responsible. Payment for these services shall be made by the Department on a fee-for-service (FFS) basis.

4.19.2 The CONTRACTOR is responsible for informing and educating members on how to access excluded services, providing all required referrals and assisting in the coordination of scheduling such services. Refer to the Managed Care Policy and Procedure Manual for detailed information on the services that will not be covered/reimbursed by the CONTRACTOR under the current Medicaid Managed Care program.

#### **4.20 Medical Necessity Determination**

4.20.1 In the provision of Core Benefit services outlined in this contract, the CONTRACTOR shall be required to provide medically necessary and evidence-based appropriate care to Medicaid Managed Care Members.

4.20.2 Core benefits shall be furnished in accordance with medical necessity and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries up to the limits as specified in the Medicaid fee-for-service (FFS) program as defined in the State Plan, administrative rule and Department policy, procedure manuals.

4.20.3 “Medically Necessary” means that the service (the provision of which may be limited by specific manual provisions, bulletins, and other directives) is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability.

4.20.4 The CONTRACTOR shall establish procedures for the determination of medical necessity. The determination of medical necessity shall be made on a case-by-case basis and in accordance with the definition of medical necessity defined by the Department and regulations. This requirement should not be construed as to limit the CONTRACTOR’s ability to use medically appropriate cost effective alternative services.

4.20.5 The Department shall make the final interpretation of any disputes about medical necessity and continuation of Core benefits covered under this Contract. The decision by the Department shall be considered final and binding upon the CONTRACTOR.

- 4.20.6 In the event the amount, duration and/or scope of services is modified under the Medicaid fee-for-service program, the CONTRACTOR is responsible for provision of the service unless otherwise exempted by the Department.
- 4.20.7 The CONTRACTOR will honor and pay for core benefits for new Medicaid Managed Care Members or when a new benefit is added as a core benefit in accordance with this contract.

#### **4.21 Moral and Religious Objection**

- 4.21.1 If CONTRACTOR's subcontracted providers elect not to provide coverage of a service covered under the contract because of an objection on moral or religious grounds, the CONTRACTOR shall furnish information to the Medicaid Managed Care Member on how to receive the service.
- 4.21.2 In addition, the CONTRACTOR must have a method for identifying such providers and notifying the Department of the providers that will not provide the service.
- 4.21.3 The CONTRACTOR must:
- 4.21.3.1 Provide notice to potential Medicaid Managed Care Members before and during enrollment.
  - 4.21.3.2 Maintain a list of providers who do not participate in family planning and make that list available to the Department by the 15th of each month;
  - 4.21.3.3 Have a process of informing current Medicaid Managed Care Members of providers who do not provide certain services;
  - 4.21.3.4 Update the provider directory on a monthly basis to identify providers that do not provide a covered service due to moral or religious grounds.

### **5 CARE COORDINATION**

#### **5.1 Care Management**

- 5.1.1 As part of the Care Management System, the CONTRACTOR shall perform care management activities as to arrange, assure delivery of, monitor, and evaluate the care received by its Members. Care Management activities shall conform to the requirements and industry standards stipulated in the NCQA requirements for Complex Case Management and by the *Standards of Practice of Case Management* released by the Case Management Society of America.
- 5.1.2 The CONTRACTOR, using either its own mechanism or by using the 3M Clinical Risk Grouping (CRG) score provided by the Department, shall stratify its Members based on risk. The CONTRACTOR shall classify each Member as being low, moderate, or high risk. The high-risk group shall approximate a 3M CRG score of 5 or greater.

- 5.1.3 The Department may require specific risk assessment tools for special population groups as stipulated in Section 4 of this Contract and defined in the Managed Care Policy and Procedure Manual.
- 5.1.4 The CONTRACTOR shall provide care management, wellness promotion, and illness prevention activities based on the Member's risk stratification.
- 5.1.4.1 The CONTRACTOR shall provide members at low risk with prevention and wellness messaging and condition-specific materials.
- 5.1.4.2 The CONTRACTOR shall provide members at moderate risk with interventions targeted at the Member's specific problems and aimed at improving overall health and preventing any further disease progression or increase in risk.
- 5.1.4.3 The CONTRACTOR shall provide members at high risk with intensive case management.
- 5.1.4.4 In determining the appropriate level of care management, the CONTRACTOR shall also take into account any referral from a Provider or the Department.
- 5.1.4.5 The CONTRACTOR shall also take into account concurrent mental illness and substance abuse disorders when evaluating the appropriate level of intervention.
- 5.1.5 The CONTRACTOR shall submit monthly to the Department, in a format stipulated in the Managed Care Policy and Procedure Manual, a report of all members receiving Care Management.
- 5.1.6 The CONTRACTOR shall develop guidelines for Care Coordination that will be submitted to the Department for review and approval. The CONTRACTOR shall have approval from the Department for any subsequent changes prior to implementation of such changes.

## **5.2 Transition of Care**

- 5.2.1 The CONTRACTOR shall be responsible for the cost of the continuation of services to a new Medicaid Managed Care Member. Responsibilities include:
- 5.2.1.1 For a new Medicaid Managed Care Member entering the CONTRACTOR's Health Plan who is receiving medically necessary Medicaid services the day before enrollment;
- 5.2.1.2 For a new Medicaid Managed Care Member entering the CONTRACTOR's Health Plan who before enrollment has received prior authorization for medically necessary covered services from an out-of-network provider, another CONTRACTOR, or Medicaid fee-for-service;

- 5.2.1.3 Continuation of services applies whether such services were provided by another CONTRACTOR (“MCO”) or through Medicaid fee-for-service (FFS);
- 5.2.1.4 No prior approval is required;
- 5.2.1.5 The CONTRACTOR is responsible for costs regardless of whether services are provided by contracted or out-of-network providers;
- 5.2.1.6 The CONTRACTOR shall be responsible for continuing such services for the lesser of up to sixty (60) calendar days OR until the CONTRACTOR has performed appropriate clinical review and transferred the Member to a contracted provider, without disruption of services;
- 5.2.1.7 The CONTRACTOR may require prior authorization for continuation of services beyond sixty (60) calendar days; however, the CONTRACTOR is prohibited from denying authorization solely on the basis that the provider is out-of-network;
- 5.2.1.8 The CONTRACTOR may require the Medicaid Managed Care Member to receive a previously authorized service from a contracted provider if the service has not yet been scheduled and the member does not have an appointment. After sixty (60) days the CONTRACTOR may require a new prior authorization for the service(s);
- 5.2.1.9 For a new Medicaid Managed Care Member who is an inpatient at the time of enrollment in the CONTRACTOR’s Health Plan, facility charges shall be the responsibility of the previous CONTRACTOR or Medicaid fee-for-service in accordance with the Managed Care Policy and Procedure Manual.
- 5.2.1.10 For a new Medicaid Managed Care Member who is an inpatient at the time of enrollment in the CONTRACTOR’s Health Plan, professional charges shall be the responsibility of the new CONTRACTOR.
- 5.2.1.11 Notwithstanding the above provisions, the CONTRACTOR shall provide transition of care for new Medicaid Managed Care Members who are pregnant or receiving inpatient care as follows:
- 5.2.1.11.1 Prenatal Care (first trimester)

5.2.1.11.1.1 For a new Medicaid Managed Care Member entering the CONTRACTOR's Health Plan in the first trimester of pregnancy who is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services without any form of prior approval and without regard to whether such services are being provided by a contracted or out-of-network provider until such time as the CONTRACTOR can reasonably transfer the member to a contract provider without impeding service delivery that, if not provided, might be harmful to the member's health. Medically necessary prenatal services include:

- Prenatal care,
- Delivery, and
- Post-natal care

5.2.1.11.2 Prenatal Care (second or third trimester)

5.2.1.11.2.1 For a new Medicaid Managed Care Member entering the CONTRACTOR's Health Plan in the second or third trimester of pregnancy who is receiving medically necessary covered prenatal care services the day before enrollment, the CONTRACTOR shall be responsible for providing continued access to the prenatal care provider (whether a contracted or out-of-network provider) through the postpartum period.

5.2.2 The CONTRACTOR shall develop and implement policies and procedures to address transition of care consistent with the Managed Care Policy and Procedure Manual for new members, members who transition between CONTRACTOR's, members who transition from fee-for-service (FFS) and members still enrolled upon termination or expiration of the contract. At a minimum, the CONTRACTOR must develop a process to identify and address transition of:

- 5.2.2.1 Members with significant medical conditions including but not limited to individuals with high-risk pregnancies, individuals with chronic illnesses, individuals with special health care needs, and individuals receiving organ transplants,
- 5.2.2.2 Members who are receiving on-going services such as dialysis, home health, and chemotherapy,
- 5.2.2.3 Members who have received prior authorization for services such as surgeries, post-surgical follow-up visits, or out-of-network specialty care.

- 5.2.2.4 Additional information regarding this requirement may be found in the Managed Care Policy and Procedure Manual.
- 5.2.3 The CONTRACTOR shall designate a person with appropriate training and experience to act as the Transition Coordinator. This staff person shall interact closely with the Department's staff and staff from other CONTRACTOR's to ensure a safe and orderly transition.
- 5.2.4 The CONTRACTOR shall develop a transition plan that provides a detailed description of the process of transferring Medicaid Managed Care Members from out-of-network providers to the CONTRACTOR's provider network to ensure optimal continuity of care. The transition plan shall include, but not be limited to, a timeline for transferring Medicaid Managed Care Members, description of provider clinical record transfers, scheduling of appointments, proposed prescription drug protocols, and claims approval for existing providers during the transition period. The CONTRACTOR shall document its efforts relating to the transition plan in the Medicaid Managed Care Member's records.
- 5.2.5 Upon notification of enrollment of a new member, the receiving CONTRACTOR or new PCP shall assist the member with requesting copies of the member's medical record from treating providers, unless the member has arranged for the transfer. Transfer of records shall not interfere or cause delay in providing services to the member.
- 5.2.6 When relinquishing Medicaid Managed Care Members, the CONTRACTOR shall cooperate with the Department and new treating providers in a receiving CONTRACTOR's network or fee-for-service (FFS) Medicaid regarding the course of ongoing care with a specialist or other provider. The relinquishing CONTRACTOR is responsible for providing timely notification and needed information to the Department, or its designee, regarding pertinent information related to any special needs of transitioning members. Such information includes, but is not limited to provision of any transitioning member forms required by the Department, information regarding historical claims paid, and information regarding currently authorized services.

### **5.3 Continuity of Care**

- 5.3.1 The CONTRACTOR shall develop and maintain effective continuity of care activities to ensure a continuum approach to treating and providing health care services to Medicaid Managed Care Members.
- 5.3.2 In addition to ensuring appropriate referrals, monitoring, and follow-up to providers within the network, the CONTRACTOR shall ensure appropriate linkage and interaction with providers outside the network.

- 5.3.2.1 The CONTRACTOR's continuity of care activities should provide processes for effective interactions between Medicaid Managed Care Members, in-network and out-of-network providers and identification and resolution of problems if those interactions are not effective or do not occur.
- 5.3.2.2 The CONTRACTOR shall provide for continuity of care consistent with 42 CFR 438.208.
- 5.3.3 The CONTRACTOR shall provide effective continuity of care activities to ensure that the appropriate personnel, including the PCP, are kept informed of the Medicaid Managed Care Member's treatment needs, changes, progress or problems.
- 5.3.3.1 The CONTRACTOR shall ensure that service delivery is properly monitored to identify and overcome any barriers to primary and preventive care that the Medicaid Managed Care Member may encounter.
- 5.3.4 Unless otherwise required by this Contract, the CONTRACTOR shall not be obligated to directly furnish and pay for any services outside the core benefits except those included in the additional services as stipulated in this Contract.
- 5.3.4.1 The CONTRACTOR shall assist the Medicaid Managed Care Member in determining the need for services outside the Core Benefits and refer the member to the appropriate provider.
- 5.3.4.2 The CONTRACTOR shall establish a process to coordinate the delivery of core benefits with services that are reimbursed fee-for-service (FFS) by the Department.
- 5.3.4.3 The CONTRACTOR may request the assistance of the Department for referral to the appropriate service setting.
- 5.3.4.4 In the event of termination of a CONTRACTOR's provider, the CONTRACTOR will continue to pay the provider until either the Medicaid Managed Care Member has finished the course of treatment or until the provider releases the Medicaid Managed Care Member to another provider who is within the CONTRACTOR's network
- 5.3.4.5 In accordance with 42 CFR 430.10(f)(5), the CONTRACTOR must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

#### **5.4 Coordination of Referral(s) Outside of Core Benefits**

5.4.1 The CONTRACTOR shall coordinate the referral of Medicaid Managed Care Members for services that are outside of the required core benefits and which will continue to be provided by enrolled Medicaid providers. These services are consistent with the outline and definition of covered services in the State Plan. These services include, but are not limited to:

5.4.1.1 TCM services,

5.4.1.2 Intensive family treatment services,

5.4.1.3 Therapeutic day services for children,

5.4.1.4 Out-of-home therapeutic placement services for children, and

5.4.1.5 Inpatient psychiatric hospital and residential treatment facility services.

### **5.5 Health Homes (Section 2703) and Care Coordination**

5.5.1 The Department is in the process of developing Health Home(s) as permitted under Section 1945 of the Social Security Act.

5.5.2 The CONTRACTOR shall comply and cooperate with the Department in developing and implementing the Health Home initiative.

5.5.3 The Department will provide the CONTRACTOR with information regarding the structure, enrollment, provider qualifications and other related requirements regarding the Health Home as well as any changes to covered services or the CONTRACTOR's payment that may be necessary due to the approval of a Health Home State Plan Amendment(s).

## **6 NETWORKS**

### **6.1 General Requirements**

6.1.1 In accordance with 42 CFR § 438.206, the CONTRACTOR must ensure that it possesses a network of providers sufficient to provide adequate access to all services covered under this Contract. In the development and maintenance of its network, at a minimum, the CONTRACTOR must consider the following:

6.1.1.1 Anticipated Medicaid Enrollment

6.1.1.2 Expected utilization of services, taking into consideration the characteristics and health care needs of the specific Medicaid populations represented in a Department approved Geographical Service Area.

6.1.1.3 The number and types of providers required, in terms of training, experience, and specialization, to furnish the contracted Medicaid services;

6.1.1.4 The number of network providers accepting new Medicaid Managed Medicaid Members;

- 6.1.1.5 The geographic location of providers and Medicaid enrollees, considering distance, travel time, the means of transportation ordinarily used by Medicaid enrollees, and whether the location provides physical access for Medicaid enrollees with disabilities. The CONTRACTOR must utilize a geo-coding solution to verify the geographic location of providers in relation to Medicaid Managed Care Members.
- 6.1.1.6 Provides female enrollees with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.
- 6.1.1.7 Provides for a second opinion from a qualified health care professional within the network, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
- 6.1.1.8 If the network is unable to provide necessary services, covered under the contract, to a particular enrollee, the CONTRACTOR must adequately and timely cover these services out of network for the enrollee, for as long as the CONTRACTOR is unable to provide them.
- 6.1.1.9 Requires out-of-network providers to coordinate with the CONTRACTOR with respect to payment and ensures that cost to the enrollee is no greater than it would be if the services were furnished within the network.
- 6.1.1.10 Demonstrates that its providers are credentialed as required by 42 CFR § 438.214 and this Contract.
- 6.1.1.11 In developing its network, the CONTRACTOR shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider, whether participating or nonparticipating, who is acting within the scope of the provider's license or certification under applicable state law, solely on the basis of such license or certification, in accordance with § 1932(b) (7) of the Social Security Act.
- 6.1.1.11.1 The CONTRACTOR shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who services high-risk populations or specializes in conditions that require costly treatment.

6.1.1.11.2 If the CONTRACTOR declines to include individual or groups of providers, it must give written notice of the reason for its decision. 42 CFR § 438.121(a) of this section may not be construed to:

6.1.1.11.2.1 Require the CONTRACTOR to contract with providers beyond the number necessary to meet the needs of its enrollees.

6.1.1.11.2.2 Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

6.1.1.11.2.3 Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to enrollees.

6.1.1.12 Furnishing of services

6.1.1.12.1 Each CONTRACTOR must do the following to ensure timely access:

6.1.1.12.1.1 Meet and require its providers to meet the Department's standards for timely access to care and services, taking into account the urgency of the need for services.

6.1.1.12.1.2 Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees.

6.1.1.12.1.3 Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.

6.1.1.12.1.4 Establish mechanisms to ensure compliance by providers.

6.1.1.12.1.5 Monitor providers regularly to determine compliance.

6.1.1.12.1.6 Take corrective action if there is a failure to comply.

6.1.1.13 Cultural considerations

6.1.1.13.1 The CONTRACTOR shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

**6.2 Provider Network**

6.2.1 The CONTRACTOR shall establish and maintain, through written agreements, an appropriate Provider Network necessary for the provision of the services under this Contract. This includes, but is not limited to Primary Care Providers (PCPs), Specialty Providers, Hospitals and other Health Care Service Providers as identified by the Department. For geographic areas lacking Providers sufficient in number, mix, and geographic distribution to meet the needs of the number of members in the service area, the Department at its sole discretion may waive the distance requirement.

## 6.2.2 General Provider Network Requirements

### 6.2.2.1 Primary Care Provider (PCP)

- 6.2.2.1.1 Each of the CONTRACTOR's Medicaid members must have access to at least one PCP with an open panel within thirty (30) miles of their place of residence.
- 6.2.2.1.2 The CONTRACTOR shall ensure that its contracted primary care providers have an appointment system that meets the following access standards:
  - 6.2.2.1.2.1 Routine visits scheduled within four (4) weeks.
  - 6.2.2.1.2.2 Urgent, non-emergent visits within forty-eight (48) hours.
  - 6.2.2.1.2.3 Emergent visits immediately upon presentation at a service delivery site.
  - 6.2.2.1.2.4 Waiting times that do not exceed forty-five (45) minutes for a scheduled appointment of a routine nature.
  - 6.2.2.1.2.5 Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.
  - 6.2.2.1.2.6 Provide twenty-four (24) hour coverage by direct access or through arrangement with a triage system.
  - 6.2.2.1.2.7 The CONTRACTOR must monitor the adequacy of its appointment processes.

### 6.2.2.2 Specialists

- 6.2.2.2.1 The CONTRACTOR is required to contract with required specialists identified in Table 6.1 (*aka* Status 1 Providers).
- 6.2.2.2.2 Each of the CONTRACTOR's Medicaid members must have access to Specialists within fifty (50) miles of their place of residence.
- 6.2.2.2.3 The Department may identify additional specialists that will be required for a specific geographic area.

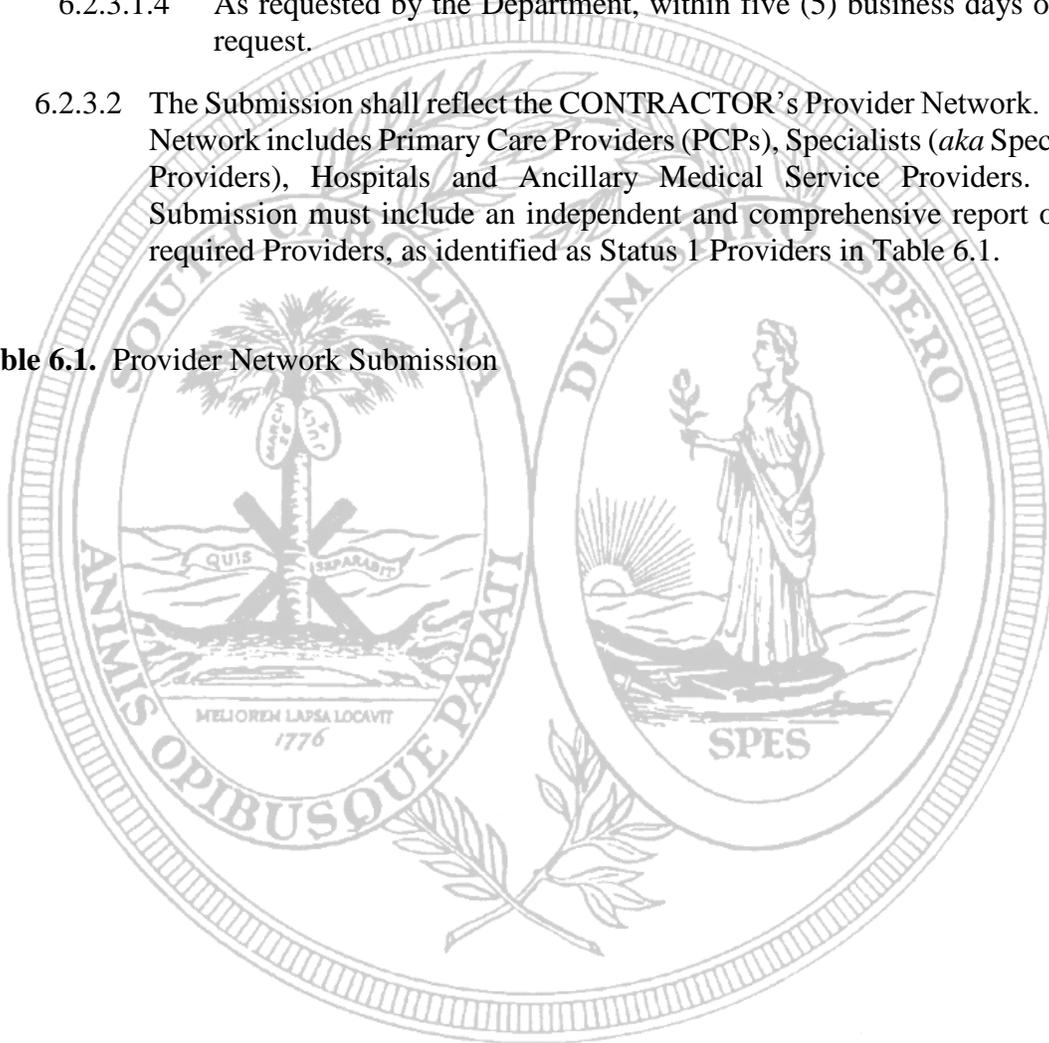
- 6.2.2.2.4 The CONTRACTOR must make available a choice of at least two (2) required contracted specialists and/or subspecialists who are accepting new patients within the geographic area.
- 6.2.2.2.5 For specialty referrals, the CONTRACTOR must be able to provide for:
- 6.2.2.2.5.1 Emergent visits immediately upon referral
  - 6.2.2.2.5.2 Urgent medical condition care appointments within forty-eight (48) hours of referral or notification of the Primary Care Physician.
  - 6.2.2.2.5.3 Scheduling of appointments for routine care (non-symptomatic) within four (4) weeks and a maximum of twelve (12) weeks for unique specialists.
- 6.2.2.3 Hospitals
- 6.2.2.3.1 Hospital Providers must be qualified to provide services under the Medicaid program.
  - 6.2.2.3.2 Each of the CONTRACTOR's Medicaid members must have access to at least one Hospital within fifty (50) miles of their place of residence.
- 6.2.2.4 Other Health Care Service Providers (Ancillary Service Providers)
- 6.2.2.4.1 Other Health Care Service Providers (*aka* Ancillary Service Providers) must be qualified to provide services under the Medicaid program.
- 6.2.3 **Provider Network Submission**
- 6.2.3.1 The CONTRACTOR shall submit its Provider Network to the Department in accordance with 42 CFR § 438.207(d) and as detailed in the Managed Care Policy and Procedure Guide. The submission shall be due as specified by the Department, but no less frequently than:
    - 6.2.3.1.1 No later than ninety (90) days prior to the intended date for entry into a new geographic area;
    - 6.2.3.1.2 Bi-annually thereafter, on August 15 reflecting the CONTRACTOR's network as of July 1, and on February 15 reflecting the CONTRACTOR's network as of January 1;

6.2.3.1.3 Prior to any significant changes in the network, where such changes in the entity's operations would affect adequate capacity and services; including: changes in services, benefits, geographic area or payments, or enrollment of a new population in CONTRACTOR's plan, or a provider termination. The CONTRACTOR shall notify the Department of any significant change within seven (7) business days of receiving such notice but no later than sixty (60) days from the effective date of the change;

6.2.3.1.4 As requested by the Department, within five (5) business days of the request.

6.2.3.2 The Submission shall reflect the CONTRACTOR's Provider Network. This Network includes Primary Care Providers (PCPs), Specialists (*aka* Specialty Providers), Hospitals and Ancillary Medical Service Providers. This Submission must include an independent and comprehensive report of all required Providers, as identified as Status 1 Providers in Table 6.1.

**Table 6.1.** Provider Network Submission



NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE	STATUS	DEPARTMENT COMMENTS
<b>ANCILLARY SERVICES</b>		
Ambulance Services	3	
Durable Medical Equipment	1	
Orthotics/Prosthetics	1	
Home Health	1	
Infusion Therapy	1	
Laboratory/X-Ray	1	
Pharmacies	1	
Hospitals	1	
<b>PRIMARY CARE PROVIDERS</b>		
Family/General Practice	1	
Internal Medicine	1	
RHC's/FQHC's	2	Not required but may be utilized as a PCP provider
Pediatrics	1	
OB/GYN	1	Serving as PCP for pregnant women, follow Proximity Guidelines for Primary Care Providers
<b>SPECIALISTS</b>		
Allergy/Immunology	3	
Anesthesiology	3	
Audiology	3	
Cardiology	1	
Chiropractic	3	
Dental	4	
Dermatology	3	
Emergency Medical	3	
Endocrinology and Metabolism	3	
Gastroenterology	1	
Hematology/Oncology	1	
Infectious Diseases	1	

NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE	STATUS	DEPARTMENT COMMENTS
Licensed Professional Counselor	1	These include the following: <ul style="list-style-type: none"> <li>Licensed Independent Social Worker</li> <li>Licensed Marriage &amp; Family Therapist</li> <li>Licensed Psycho-Educational Therapist</li> </ul>
Neonatology	3	
Nephrology	1	
Neurology	1	
Nuclear Medicine	3	
OB/GYN	1	
Ophthalmology	1	
Optician	4	
Optometry	1	
Orthopedics	1	
Otorhinolaryngology	1	
Pathology	3	
Pediatrics, Allergy	3	
Pediatrics, Cardiology	3	
Podiatry	3	
Psychiatry (private)	1	
Psychologist	1	
Pulmonary Medicine	1	
Radiology, Diagnostic	3	
Radiology, Therapeutic	3	
Rheumatology	3	
Surgery – General	1	
Surgery – Thoracic	3	
Surgery – Cardiovascular	3	
Surgery – Colon and Rectal	3	
Surgery – Neurological	3	
Surgery – Pediatric	3	
Surgery – Plastic	3	

NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE	STATUS	DEPARTMENT COMMENTS
Therapy – Occupational	1	
Therapy – Physical	1	
Therapy – Speech	1	
Urology	1	
Long-Term Care	3	CONTRACTOR responsibility begins once the Medicaid Managed Care Member has been approved for, and admitted to the Long-Term Care (LTC) facility. If the Medicaid Managed Care Member stays in the facility for ninety (90) consecutive days, the Medicaid Managed Care Member will be disenrolled from the CONTRACTOR at the earliest opportunity by the Department. The CONTRACTOR financial responsibility will not exceed one hundred and twenty (120) days total.
Status	1 = Required 2 = Not required unless serving as PCP for the county 3 = Attestation 4 = Attest, if offered	

### 6.3 Attestation(s)

6.3.1 The CONTRACTOR must submit attestation(s) for all Provider types identified as Status 3 or 4 in Table 6.1.

### 6.4 Regional Provider Networks

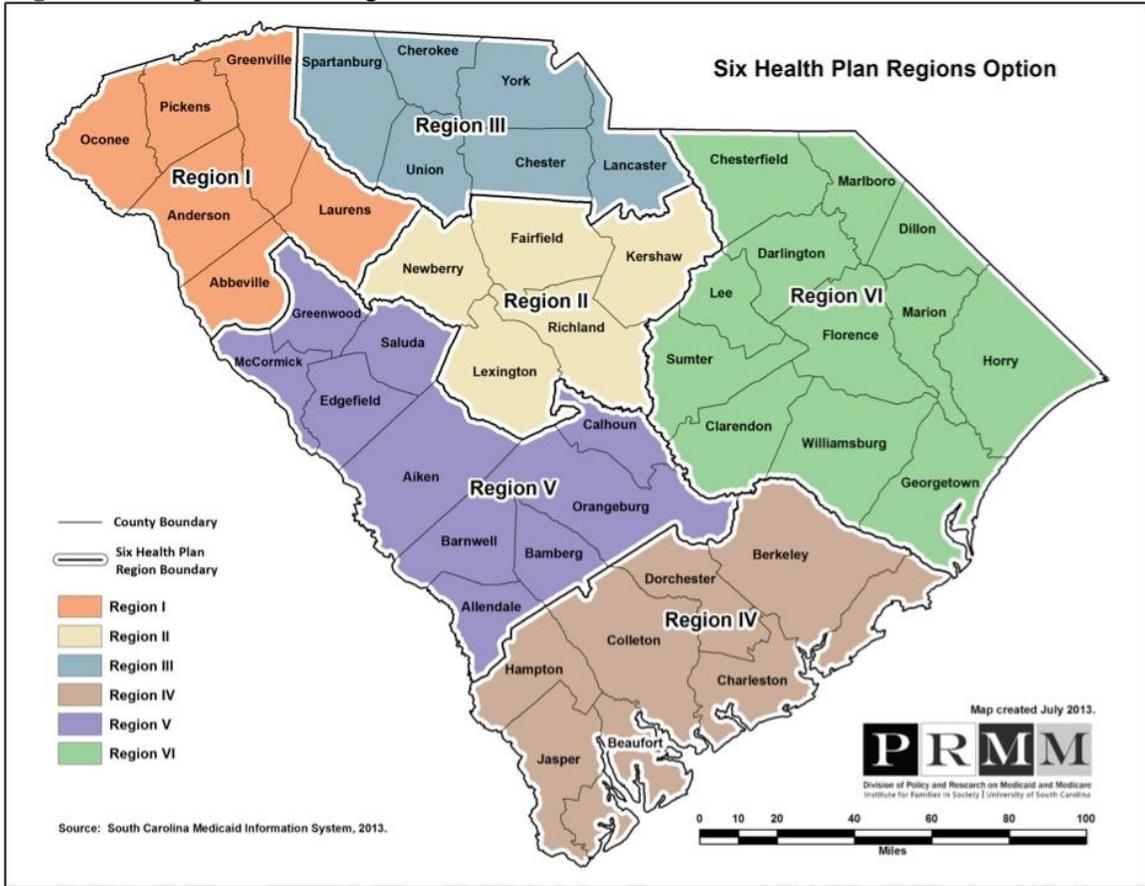
6.4.1 The Department is in process of developing a Six Region Provider Network Model for implementation on July 1, 2015. See Figure 6.1.

6.4.1.1 The CONTRACTOR agrees to comply and cooperate with the Department throughout the development and implementation of this Regional Model.

6.4.1.2 The Department will provide the CONTRACTOR with information regarding the structure, enrollment, provider qualifications and other related requirements regarding the Six Region Provider Network. The Department agrees to provide this information within a sufficient and appropriate amount of time for CONTRACTOR to implement by July 1, 2015.

6.4.2 The Regional Provider Network Model will be incorporated into this agreement through Contract amendment.

**Figure 6.1 Proposed Six-Region Provider Network Model**



## 7 PAYMENTS

### 7.1 Financial Management

- 7.1.1 The CONTRACTOR shall be responsible for sound fiscal management of the health care plan developed under this Contract. The CONTRACTOR shall adhere to the minimum guidelines outlined herein.

### 7.2 Capitation Payments from the Department to CONTRACTOR

- 7.2.1 The Department agrees to make, and the CONTRACTOR agrees to accept, the Capitation Payments as outlined in Appendix B, and any other authorized payments, as payment in full for all services provided to Medicaid Managed Care Members pursuant to this Contract.
- 7.2.2 The Capitation Payment is equal to the monthly number of Medicaid Managed Care Members in each category multiplied by the capitation rate established for each category per month plus a maternity kicker payment for each Medicaid Managed Care Member who delivers during the month.
- 7.2.3 To the extent there are material changes, as determined by the Department, to the Medicare fee schedule and subsequent changes to the Medicaid fee schedule during the Contract period, the Department reserves the right to adjust the capitation rates accordingly.
- 7.2.4 No more frequently than once during each Department Fiscal Year (*aka* State Fiscal Year (SFY); July 1<sup>st</sup> to June 30<sup>th</sup>), the Department reserves the right to defer remittance of the Capitation Payment to the CONTRACTOR.
- 7.2.4.1 The Department will notify CONTRACTOR of such deferral at least fourteen (14) business days prior to the expected payment date.
- 7.2.4.2 The Department may defer the Capitation Payment for a period not longer than thirty-three (33) calendar days from the original payment date to comply with the Department's fiscal policies and procedures.
- 7.2.5 In the event the federal government lifts any moratorium on supplemental payments to physicians or facilities, capitation rates in this Contract will be adjusted accordingly.
- 7.2.6 In the event that the Department pays a provider a fee-for-service (FFS) payment for services which are covered under the CONTRACTOR's capitated rates, when those services were provided to a Medicaid beneficiary during the time frame the beneficiary was enrolled or retroactively enrolled in the CONTRACTOR's plan, the CONTRACTOR shall either:
- 7.2.6.1 Repay the Department the fee-for-service (FFS) payment made by the Department during the time frame the Member was covered under the CONTRACTOR's Plan; or,

- 7.2.6.2 Require the provider to refund the fee-for-service payment to the Department and then pay the provider the amount allowed for the service under the CONTRACTOR'S Plan.
- 7.2.6.3 The CONTRACTOR shall be responsible for reporting to the Department collections and repayments arising from this situation.
- 7.2.6.4 The Department may at its discretion limit the recoupment period for improper fee-for-service payments for managed care members. Such limitation should allow the provider to bill the CONTRACTOR appropriately.

7.2.7 **Health Insurance Fee**

- 7.2.7.1 Section 9010 of the Patient Protection and Affordable Care Act Pub. L. No. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (124 Stat. 1029 (2010)) imposes an annual fee on health insurance providers beginning in 2014 ("Annual Fee"). The CONTRACTOR is responsible for a percentage of the Annual Fee for all health insurance providers as determined by the ratio of CONTRACTOR's net written premiums for the preceding year compared to the total net written premiums of all entities subject to the Annual Fee for the same year.
- 7.2.7.2 The State shall reimburse the CONTRACTOR for the amount of the Annual Fee specifically allocable to the premiums paid during this Contract Term for each calendar year or part thereof, including an adjustment for the full impact of the non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("CONTRACTOR's Adjusted Fee"). The CONTRACTOR's Adjusted Fee shall be determined based on the final notification of the Annual Fee amount CONTRACTOR or CONTRACTOR's parent receives from the United States Internal Revenue Service. The State will provide reimbursement following its review and acceptance of the CONTRACTOR's Adjusted Fee.
- 7.2.7.3 To claim reimbursement for the CONTRACTOR's Adjusted Fee, the CONTRACTOR must submit a certified copy of its full Annual Fee Assessment within sixty (60) days of receipt, together with the allocation of the Annual Fee attributable specifically to its premiums under this contract. The CONTRACTOR must also submit the calculated adjustment for the impact of non-deductibility of the Annual Fee attributable specifically to its premiums under this Contract, and any other data deemed necessary by the Department to validate the reimbursement amount. These materials shall be submitted under the signatures of either its Financial Officer or Executive

leadership (e.g., President, Chief Executive Office, Executive Director), certifying the accuracy, truthfulness and completeness of the data provided.

### **7.3 Payments from CONTRACTOR to Subcontractor**

#### **7.3.1 Payment to Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)**

7.3.1.1 The Capitation Payment to the CONTRACTOR includes the units and expenditures applicable to the FQHCs and RHCs. However, appropriate adjustments are made to the claims data to make FQHC and RHC encounter payment levels equivalent to fee-for-service payment levels.

7.3.1.2 The CONTRACTOR shall not make payment to a FQHC/RHC that is less than the level and amount of payment that the CONTRACTOR makes for similar services to other Providers.

7.3.1.3 The CONTRACTOR shall not make payment to a FQHC/RHC that is less than the level and amount of payment that the FQHC/RHC would have been entitled to receive as reimbursement from the South Carolina Medicaid Program for a fee-for-service claim. The CONTRACTOR may elect to make payment to the FQHC/RHC at a level and amount that exceeds the Medicaid fee-for-service (FFS) reimbursement amount.

7.3.1.4 The CONTRACTOR shall submit the name of each FQHC/RHC and detailed Medicaid encounter data (i.e. Medicaid recipient data, payment data, service/CPT codes) paid to each FQHC/RHC by month of service to the Department for State Plan required reconciliation purposes. This information shall be submitted in the format required by the Department as contained in the Managed Care Policy and Procedure Manual

#### **7.3.2 Co-payments**

7.3.2.1 Co-payments for Adult Medicaid Managed Care Members age 19 years and older will be allowed under this Contract. Any cost sharing imposed on Medicaid Managed Care Members must be in accordance with 42 CFR §§ 447.50 to 447.58 as authorized under the State Plan and respective Coverage Manual.

#### **7.3.3 Emergency Services**

7.3.3.1 Emergency services that are provided including, but are not limited to:

7.3.3.1.1 Radiology,

7.3.3.1.2 Pathology,

7.3.3.1.3 Emergency medicine, and

7.3.3.1.4 Anesthesiology

- 7.3.3.2 When the CONTRACTOR's Medicaid Managed Care Member is provided these emergency services as an inpatient or on an outpatient basis, the CONTRACTOR shall reimburse the professional component of these services at no more than the Medicaid fee-for-service (FFS) rate. Specifically, Section 1932(b)(2)(B) of the Act, limits payment for emergency services provided contracted or non-contracted provider to no more than the amount that would have been paid if the service had been provided under the State's Fee-For-Service (FFS) Medicaid program.
- 7.3.3.3 Prior authorization for these inpatient services shall not be required of either network or non-participating Providers.

#### **7.4 Payment Standards**

- 7.4.1 Regardless of the payment methodology (fee-for-service or capitated rate) Medicaid cannot pay for services that are not medically necessary, as defined in this contract.
- 7.4.2 The CONTRACTOR must ensure that the payment and health care coverage policies for the network providers include this requirement, and have an approved definition of "Medically Necessary" in the provider manuals and handbooks consistent with Section 4 of this Contract.
- 7.4.3 The CONTRACTOR must also require that a provider's medical records or other appropriate documentation for each beneficiary substantiate the need for services, must include all findings and information supporting medical necessity and justification for services, and must detail all treatment provided.
- 7.4.4 The CONTRACTOR's policies and billing requirements for providers must, at minimum, follow CPT and HCPCS standards and guidelines where applicable.
- 7.4.5 The CONTRACTOR must follow all applicable federal and state rules in setting rates and policy for medical services, and ensure that policy and coverage guidelines include restrictions or prohibitions for certain services that cannot be paid for within the Medicaid program. These include (but are not limited to):
- 7.4.5.1 Services that are a result of a hospital-acquired condition (HAC) or provider-preventable condition (PPC);
  - 7.4.5.2 Services that are cosmetic or experimental
  - 7.4.5.3 Other non-covered services as specified in the Managed Care Policy and Procedures Guidelines.
- 7.4.6 At minimum, the CONTRACTOR must apply NCCI edits on a prepayment basis, in accordance with CMS requirements and approved State Plan.
- 7.4.7 Pursuant to 42 CFR § 447.45, and subject to the limitations stated therein:

- 7.4.7.1 The CONTRACTOR must pay ninety percent (90%) of all clean claims from Providers, within thirty (30) calendar days of the date of receipt; and
- 7.4.7.2 The CONTRACTOR must pay ninety-nine percent (99%) of all clean claims from Providers, within ninety (90) calendar days of the date of receipt.
- 7.4.7.3 The CONTRACTOR may, by mutual agreement, establish an alternative payment schedule than specified above.

## **7.5 Prohibited Payments**

- 7.5.1 Payment for the following shall not be made by the CONTRACTOR:
  - 7.5.1.1 Non-emergency services provided by or under the direction of an excluded individual;
  - 7.5.1.2 Any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
  - 7.5.1.3 Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan; and
  - 7.5.1.4 Any amount expended for home health care services unless the organization provides the appropriate surety bond.

## **7.6 Return of Funds**

- 7.6.1 The Contractor agrees that all amounts identified as being owed to the Department are due immediately upon notification to the Contractor by the Department unless otherwise authorized in writing by the Department. The Department, at its discretion, reserves the right to collect amounts due by withholding future Capitation Payments. The Department reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification. The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR 30.13. This rate may be revised quarterly by the Secretary of the Treasury and shall be published by the United States Department of Health and Human Services (HHS) in the Federal Register.
- 7.6.2 Payment of funds being returned to the Department shall be submitted to:

South Carolina Department of Health and Human Services  
Department of Receivables  
Post Office Box 8355  
Columbia, South Carolina 29202-8355

## **8 UTILIZATION MANAGEMENT**

### **8.1 Management**

- 8.1.1 The CONTRACTOR shall develop and maintain policies and procedures with defined structures and processes for a Utilization Management (UM) program that incorporates Utilization Review and Service Authorization.
- 8.1.2 The CONTRACTOR shall submit UM policies and procedures to the Department for approval within thirty (30) days from effective date of this Contract, annually thereafter, and prior to any revisions.

### **8.2 CONTRACTOR Utilization Management (UM) Program Requirements**

- 8.2.1 The UM program description shall be exclusive to the South Carolina Medicaid Managed Care Program and shall not contain documentation from other state Medicaid programs or product lines operated by the CONTRACTOR.
- 8.2.2 At a minimum, these policies and procedures shall be consistent with 42 CFR § 456 and address the following:
  - 8.2.2.1 Process for monitoring over and under-utilization of services consistent with 42 CFR § 238.240(b)(3).
  - 8.2.2.2 The methodology utilized to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;
  - 8.2.2.3 Protocols for service authorization and denial of services; the process used to evaluate prior and concurrent authorization.
  - 8.2.2.4 Documentation requirements regarding clinical review;
  - 8.2.2.5 Mechanisms to ensure consistent application of review criteria and compatible decisions;
  - 8.2.2.6 Data collection processes and analytical methods used in assessing utilization of health care services; and
  - 8.2.2.7 Provisions for assuring confidentiality of clinical and proprietary information.
  - 8.2.2.8 The CONTRACTOR shall have written procedures listing the information required from a member or health care provider in order to make medical necessity determinations. Such procedures must be made available upon request by a Medicaid Managed Care Member or provider.
  - 8.2.2.9 The CONTRACTOR shall have sufficient staff with clinical expertise and training to apply service authorization medical management criteria and practice guidelines.

- 8.2.3 The CONTRACTOR shall use the Department's medical necessity definition for medical necessity determinations.
- 8.2.3.1 The CONTRACTOR shall ensure that only licensed clinical professionals with appropriate clinical expertise shall determine service authorization request, denials, or authorize a service in an amount, duration or scope that is less than requested.
- 8.2.3.2 The CONTRACTOR's service authorization systems shall notify the requesting provider, and give the Medicaid Managed Care Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested in accordance with 42 CFR § 438.210(c).
- 8.2.3.3 The CONTRACTOR shall ensure that compensation to individuals or entities that conduct UM and SA activities is not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary covered services to any member in accordance with 42 CFR § 438.210(e).
- 8.2.3.4 The CONTRACTOR shall report fraud and abuse information identified through the UM program to the Department's Program Integrity (PI) Unit in accordance with the requirements established in Section 11 of this contract.

### **8.3 Practice Guidelines**

- 8.3.1 The CONTRACTOR shall possess the expertise and resources to ensure the delivery of quality health care services to Medicaid Managed Care Members in accordance with the Medicaid Program standards and the prevailing medical community standards.
- 8.3.2 In accordance with 42 CFR § 438.236(b), the CONTRACTOR shall adopt practice guidelines that:
- 8.3.2.1 Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- 8.3.2.2 Consider the needs of the Medicaid Managed Care Members.
- 8.3.2.3 Are adopted in consultation with contracting health care professionals.
- 8.3.2.4 Are reviewed and updated periodically as appropriate.
- 8.3.3 The CONTRACTOR shall disseminate the guidelines to all affected providers and, upon request, to Medicaid Managed Care Members and potential Medicaid Managed Care Members. Distribution methods may include posting on the CONTRACTOR's website and provision of written materials upon request.

- 8.3.4 The CONTRACTOR must ensure that decisions for utilization management, Medicaid Managed Care Member education, coverage of services and other areas to which guidelines apply should be consistent with the guidelines.
- 8.3.5 The CONTRACTOR shall establish a process to encourage adoption of the guidelines.

#### **8.4 Service Authorization**

- 8.4.1 The CONTRACTOR shall develop a service authorization process. Service authorization includes, but is not limited to, prior authorization and concurrent authorization and includes requests for the provision of covered services submitted by a provider.
- 8.4.2 The CONTRACTOR shall develop policies and procedures for service authorization procedures consistent with 42 CFR § 438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:
- 8.4.2.1 Written policies and procedures for processing requests for initial and continuing authorizations of services;
- 8.4.2.2 Mechanisms to ensure consistent application of review criteria for authorization decisions and consultation with the requesting provider as appropriate;
- 8.4.2.3 Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a health care professional who has appropriate clinical expertise in treating the Medicaid Managed Care Member's condition or disease;
- 8.4.2.4 The CONTRACTOR's service authorization system shall provide the authorization number and effective dates for authorization to participating providers and applicable non-participating providers;
- 8.4.2.5 The CONTRACTOR's service authorization system shall have capacity to electronically store and report all service authorization requests, decisions made by the CONTRACTOR regarding the service requests, clinical data to support the decision, and time frames for notification of providers and members of decisions;
- 8.4.2.6 The CONTRACTOR's service authorization system shall provide notification of decisions to the requesting provider and, in cases of an adverse action, also provide written notification to the enrollee, in accordance with 42 CFR § 438.404; and

- 8.4.2.7 In developing Policy and Procedures for utilization management, the CONTRACTOR shall develop a mechanism to provide for a preferred provider program in which provider's may obtain designation based on quality. For purposes of this section, such designation shall result in the provider becoming eligible for a service authorization process that recognizes the provider's ability to manage care including but not limited to exemption from service authorizations, expedited service authorization process; service authorization process that is based on simplified documentation standards.

### **8.5 Timeframe of Service Authorization Decisions**

- 8.5.1 The CONTRACTOR's responses to requests for Service Authorizations shall not exceed the time frames specified below.

### **8.6 Standard Service Authorization**

- 8.6.1 The CONTRACTOR shall provide notice as expeditiously as the Medicaid Managed Care Member's health condition requires and within State-established time frames that may not exceed fourteen (14) calendar days following receipt of the request for service.
- 8.6.2 An extension may be granted for an additional fourteen (14) calendar days if the Medicaid Managed Care Member or the provider or authorized representative requests an extension or if the CONTRACTOR justifies a need for additional information and the extension is in the member's best interest.
- 8.6.3 The CONTRACTOR shall make concurrent review determinations within three (3) business days of obtaining the appropriate medical information that may be required.
- 8.6.4 The CONTRACTOR shall give notice to the provider and written notice to the member on the date that the timeframes expire when a service authorization decision has not been reached within the timeframe required.
- 8.6.5 Untimely service authorizations constitute a denial that the CONTRACTOR shall treat as an appealable adverse action.

### **8.7 Expedited Service Authorization**

- 8.7.1 The CONTRACTOR shall have a process for expedited service authorizations in accordance with 42 CFR § 438.210(d).

- 8.7.2 In the event a provider indicates, or the CONTRACTOR determines, that following the standard service authorization timeframe could seriously jeopardize the Medicaid Managed Care Member's life or health or ability to attain, maintain, or regain maximum function, the CONTRACTOR shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires, but no later than three (3) business days after receipt of the request for service.
- 8.7.3 The CONTRACTOR may extend the three (3) business day time period by up to fourteen (14) calendar days if the Medicaid Managed Care Member requests an extension or if the CONTRACTOR justifies the need for additional information and how the extension is in the Medicaid Managed Care Member's best interest.
- 8.7.4 The CONTRACTOR shall give notice on the date that the timeframes expire when a service authorization decision has not been reached within the timeframe required.
- 8.7.5 Untimely service authorizations constitute a denial that the CONTRACTOR shall treat as an adverse action.

### **8.8 Exceptions to Service Authorization Requirements**

- 8.8.1 The CONTRACTOR shall not require service authorization for emergency services or post-stabilization services as described in Section 4 of this Contract.
- 8.8.2 The CONTRACTOR shall not require service authorization for the continuation of medically necessary covered services of a new Medicaid Managed Care Member transitioning into the CONTRACTOR's Health Plan in accordance with Section 5 of this Contract.
- 8.8.3 Consistent with Section 5 of this Contract, the CONTRACTOR is prohibited from denying previously authorized services solely on the basis of the provider being out-of-network during a new Medicaid Managed Care Member's transition period.
- 8.8.4 The CONTRACTOR shall not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the CONTRACTOR for routine and preventive women's healthcare services and prenatal care.

### **8.9 Out-of-Network Use of Non-Emergency Services**

- 8.9.1 To the extent that the CONTRACTOR is unable to provide necessary medical services covered within the network, the CONTRACTOR shall timely cover these services out-of-network for the Medicaid Managed Care Member so long as the CONTRACTOR is unable to provide them in-network.

- 8.9.2 The CONTRACTOR shall require the out-of-network provider(s) to coordinate with respect to payment and must ensure that the cost to the Medicaid Managed Care Member is no greater than it would be if the covered services were furnished within the network.
- 8.9.3 The CONTRACTOR shall provide timely approval or denial of authorization of out-of-network use of non-emergency services through the assignment of a prior authorization number, which refers to and documents the approval.
- 8.9.4 Approval or denial must be consistent with the requirements in this Section of this Contract.
- 8.9.5 The CONTRACTOR shall provide written or electronic documentation of the approval to the out-of-network provider within one (1) business day.

## **9 GRIEVANCE AND APPEAL PROCEDURES**

### **9.1 General Procedures**

- 9.1.1 The CONTRACTOR shall establish and maintain a procedure for the receipt and prompt internal resolution of all Medicaid Managed Care Member grievances and appeals in accordance with S.C. Code Ann. §38-33-110 and 42 CFR § 438.400, et seq. The CONTRACTOR's grievance and appeals procedures, and any changes thereto, must be approved in writing by the Department prior to implementation and must include, at a minimum, the requirements set forth herein. The CONTRACTOR shall refer all Medicaid Managed Care Members who are dissatisfied in any respect with the CONTRACTOR or its Subcontractor to the CONTRACTOR's designee authorized to require corrective Action.

### **9.2 General Requirements for CONTRACTOR Grievance System**

The CONTRACTOR must have a system in place for a Medicaid Managed Care Member that includes a Grievance process, an Appeal process, and as a last resort access to the State's Fair Hearing system once the CONTRACTOR's Grievance and Appeal process has been exhausted.

#### **9.2.1 Filing Requirements**

##### **9.2.1.1 Authority to File**

- 9.2.1.1.1 A Medicaid Managed Care Member may file a Grievance and a CONTRACTOR level Appeal, and may request a State Fair Hearing, once the CONTRACTOR's Appeals process has been exhausted.

9.2.1.1.2 A Provider, acting on behalf of the Medicaid Managed Care Member and with the Medicaid Managed Care Member's written consent, may file an Appeal related to an Action. A Provider may file a grievance or request a State Fair Hearing only on the Medicaid Managed Care Member's behalf, if the Provider is acting as the Medicaid Managed Care Member's authorized representative in doing so.

9.2.1.2 Timing

9.2.1.2.1 The Medicaid Managed Care Member must be sent notice of the CONTRACTOR's Action by certified mail return receipt requested and allowed at least thirty (30) calendar days from receipt to respond to the notice.

9.2.2 Procedures

9.2.2.1 The Medicaid Managed Care Member may file a Grievance with the CONTRACTOR either orally or in writing.

9.2.2.2 The Medicaid Managed Care Member or the Provider may file an Appeal with the CONTRACTOR either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed Appeal.

**9.3 Notice of Grievance and Appeals Procedures**

9.3.1 The CONTRACTOR shall ensure that all its Medicaid Managed Care Members are informed of the State's Fair Hearing process and of the CONTRACTOR's Grievance and Appeal procedures. The CONTRACTOR's Medicaid Managed Care Member handbook shall include descriptions of the CONTRACTOR's Grievance and Appeal procedures. Forms on which Medicaid Managed Care Members may file Grievances, Appeals, concerns or recommendations to the CONTRACTOR shall be available through the CONTRACTOR, and must be provided upon the Medicaid Managed Care Members' request.

**9.4 Grievance/Appeal Records and Reports**

9.4.1 A copy of an oral Grievances log and records of disposition of written Appeals shall be retained in accordance with the provisions of S.C. Code Ann. § 38-33-110 (A)(2).

9.4.2 The CONTRACTOR shall provide the Department with a monthly written log of all active and resolved Grievances/Appeals filed by Medicaid Managed Care Members. The log will include minimum data prescribed by the Department to include, but not be limited to: Medicaid Managed Care Member's name and Medicaid number; Summary of Grievance and/or Appeal; Date of filing; Current status; Resolution; and Any resulting corrective action.

## 9.5 Handling of Grievances and Appeals

9.5.1 The Grievance and Appeal procedures shall be governed by the following requirements:

9.5.1.1 Provide Medicaid Managed Care Members any assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free telephone numbers that have adequate TTY/TTD and interpreter capability.

9.5.1.2 Acknowledge receipt of each Grievance and Appeal

9.5.1.3 Ensure that the individuals who make decisions on Grievances and Appeals are individuals

9.5.1.3.1 Who were not involved in any previous level of review or decision-making; and

9.5.1.3.2 Who, if deciding (1) an appeal of a denial based on lack of Medical Necessity; (2) a grievance regarding denial of expedited resolution of an appeal; or (3) a grievance or appeal that involves clinical issues, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the Medicaid Managed Care Member's condition or disease?

9.5.2 The process for Appeals must:

9.5.2.1 Provide that oral inquiries seeking to appeal an Action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing, unless the Medicaid Managed Care Member or the Provider requests expedited resolution. The timeline for the appeal begins with the receipt of the member's oral or written notification of appeal by the CONTRACTOR, whichever occurs first. Written confirmation of all oral requests must be received by the CONTRACTOR within the timeframe established for the resolution of CONTRACTOR level appeals or the appeal may be denied by the CONTRACTOR.

9.5.2.2 Provide the Medicaid Managed Care Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CONTRACTOR must inform the Medicaid Managed Care Member of the limited time available for this in the case of expedited resolution.

9.5.2.3 Provide the Medicaid Managed Care Member and his or her representative opportunity, before and during the Appeals process, to examine the Medicaid Managed Care Member's case file, including medical records, and any other documents and records considered during the Appeals process.

- 9.5.2.4 Include, as parties to the Appeal:
- 9.5.2.4.1 The Medicaid Managed Care Member and his or her representative; or
  - 9.5.2.4.2 The legal representative of a deceased Medicaid Managed Care Member's estate.
- 9.5.2.5 The CONTRACTOR's staff shall be educated concerning the importance of the Grievance and Appeal procedures and the rights of the Medicaid Managed Care Members and Providers.
- 9.5.2.6 The appropriate individual or body within the CONTRACTOR's Health Plan having decision-making authority, as part of the Grievance/Appeal procedure shall be identified.
- 9.5.2.7 The Department reserves the right to dictate to the CONTRACTOR the resolution of any Grievance/Appeal.

## **9.6 Notice of Action**

### **9.6.1 Language and Format Requirements**

- 9.6.1.1 The notice must be in writing and must meet the language and format requirements of 42 CFR § 438.10(c) and (d) to ensure ease of understanding.

### **9.6.2 Content of Notice**

- 9.6.3 The notice must explain the following:
- 9.6.3.1 The Action the CONTRACTOR or its Subcontractor has taken or intends to take.
  - 9.6.3.2 The reasons for the Action.
  - 9.6.3.3 The Medicaid Managed Care Member's or the Provider's right to file an appeal with the CONTRACTOR.
  - 9.6.3.4 The Medicaid Managed Care Member's right to request a State Fair Hearing, after the CONTRACTOR's Appeal process has been exhausted.
  - 9.6.3.5 The procedures for exercising the rights specified in this Section of this Contract.
  - 9.6.3.6 The circumstances under which expedited resolution is available and how to request it.
  - 9.6.3.7 The Medicaid Managed Care Member's right to have benefits continue pending resolution of the Appeal; how to request that benefits be continued; and the circumstances under which the Medicaid Managed Care Member may be required to pay the costs of these services.

#### 9.6.4 **Timing of Notice**

9.6.4.1 The CONTRACTOR must mail the notice within the following timeframes:

9.6.4.1.1 For termination, suspension, or reduction of previously authorized Covered Services, at least ten (10) calendar days before the date of Action, except as permitted under 42 CFR §§ 431.213 and 431.214.

9.6.4.1.2 For denial of payment, at the time of any Action affecting the claim.

9.6.4.1.3 For standard service authorization decisions that deny or limit services, as expeditiously as the Medicaid Managed Care Member's health condition requires, but not to exceed fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:

9.6.4.1.3.1 The Medicaid Managed Care Member, or the Provider, requests extension; or

9.6.4.1.3.2 The CONTRACTOR justifies (to the Department upon request) a need for additional information and how the extension is in the Medicaid Managed Care Member's interest.

9.6.4.2 If the CONTRACTOR extends the timeframe it must:

9.6.4.2.1 Give the Medicaid Managed Care Member written notice of the reason for the decision to extend the timeframe and inform the Medicaid Managed Care Member of the right to file a Grievance if he or she disagrees with that decision; and

9.6.4.2.2 Issue and carry out its determination as expeditiously as the Medicaid Managed Care Member's health condition requires and no later than the date the extension expires.

9.6.4.3 For service authorization decisions not reached within the timeframes specified, (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire.

9.6.4.4 For expedited service authorization decisions where a Provider indicates, or the CONTRACTOR determines, that following the standard timeframe could seriously jeopardize the Medicaid Managed Care Member's life or health or ability to attain, maintain, or regain maximum function, the CONTRACTOR must make an expedited authorization decision and provide notice as expeditiously as the Medicaid Managed Care Member's health condition requires and no later than three (3) business days after receipt of the request for service. The CONTRACTOR may extend the three (3) business days' time period by up to fourteen (14) calendar days if the Medicaid Managed Care Member requests an extension, or if the CONTRACTOR justifies (to the Department upon request) a need for additional information and how the extension is in the Medicaid Managed Care Member's interest.

9.6.4.5 The Department shall conduct periodic random audits to ensure that Medicaid Managed Care Members are receiving such notices in a timely manner.

## **9.7 Resolution and Notification**

9.7.1.1 The CONTRACTOR must dispose of Grievances, resolve each Appeal, and provide notice as expeditiously as the Medicaid Managed Care Member's health condition requires, but also within the timeframes established within this subsection of this Contract.

### **9.7.2 Specific Timeframes:**

9.7.2.1 Standard Disposition of Grievances:

9.7.2.1.1 For standard disposition of a Grievance and notice to the affected parties, the timeframe is established as ninety (90) calendar days from the day the CONTRACTOR receives the Grievance.

9.7.2.2 Standard Resolution of Appeals:

9.7.2.2.1 For standard resolution of an Appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the CONTRACTOR receives the Appeal. This timeframe may be extended under Section 9 of this Contract.

9.7.2.3 Expedited Resolution of Appeals:

9.7.2.3.1 For expedited resolution of an Appeal and notice to affected parties, the timeframe is established as three (3) business days after the CONTRACTOR receives the appeal. This timeframe may be extended under Section 9 of this Contract.

9.7.2.4 Extension of timeframes:

9.7.2.4.1 The CONTRACTOR may extend the timeframes stated in this Section of this Contract by up to fourteen (14) calendar days if: the Medicaid Managed Care Member requests the extension; or the CONTRACTOR shows (to the Department's satisfaction, upon its request) that there is need for additional information and how the delay is in the Medicaid Managed Care Member's interest.

9.7.2.4.1.1 Requirements Following Extension

9.7.2.4.1.1.1 If the CONTRACTOR extends the timeframes, it must, for any extension not requested by the Medicaid Managed Care Member, give the Medicaid Managed Care Member written notice of the extension and the reason for the delay.

9.7.3 **Format of Notice**

9.7.3.1 **Grievances**

9.7.3.1.1 The Department must establish in the Department's Managed Care Policy and Procedure Manual the method the CONTRACTOR will use to notify a Medicaid Managed Care Member of the disposition of a Grievance.

9.7.3.2 **Appeals**

9.7.3.2.1 For all Appeals, the CONTRACTOR must provide written notice of disposition. For notice of an expedited resolution, the CONTRACTOR must also make reasonable efforts to provide oral notice.

**9.7.3.3 Content of Notice of Appeal Resolution**

9.7.3.3.1 The written notice of the resolution must include the following:

9.7.3.3.1.1 The results of the resolution process and the date it was completed.

9.7.3.3.1.2 For Appeals not resolved wholly in favor of the Medicaid Managed Care Members:

9.7.3.3.1.2.1 The right to request a State Fair Hearing, and how to do so;

9.7.3.3.1.2.2 The right to request to receive benefits while the hearing is pending, and how to make the request; and

9.7.3.3.1.2.3 An explanation that the Medicaid Managed Care Member may be held liable for the cost of those benefits if the hearing decision upholds the CONTRACTOR's Action.

#### **9.7.4 Requirements for State Fair Hearings**

##### **9.7.4.1 Availability**

9.7.4.1.1 The CONTRACTOR shall send the CONTRACTOR's notice of resolution to the Medicaid Managed Care Member via certified mail, return receipt requested.

9.7.4.1.2 If the Medicaid Managed Care Member has exhausted the CONTRACTOR level Appeal procedures, the Medicaid Managed Care Member may request a State Fair Hearing related to the CONTRACTOR's resolution within thirty (30) calendar days.

9.7.4.1.3 The thirty (30) calendar day period is counted from the date the Medicaid Managed Care Member receives the CONTRACTOR's notice of resolution or CONTRACTOR receives a failure of delivery notification from the return receipt requested.

##### **9.7.4.2 Parties**

9.7.4.2.1 The parties to the State Fair Hearing include the CONTRACTOR as well as the Medicaid Managed Care Member and his or her representative or the representative of a deceased Medicaid Managed Care Member's estate.

#### **9.7.5 Expedited Resolution of Appeals**

9.7.5.1 The CONTRACTOR must establish and maintain an expedited review process for Appeals, where the CONTRACTOR determines (in response to a request from the Medicaid Managed Care Member) or the Provider indicates (in making the request on the Medicaid Managed Care Member's behalf or supporting the Medicaid Managed Care Member's request) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

##### **9.7.5.2 Punitive Action**

9.7.5.2.1 The CONTRACTOR must ensure that punitive action is not taken against a Provider who requests an expedited resolution or supports a Medicaid Managed Care Member's appeal.

##### **9.7.5.3 Action Following Denial of a Request for Expedited Resolution**

9.7.5.4 If the CONTRACTOR denies a request for expedited resolution of an Appeal, it must:

9.7.5.4.1 Transfer the Appeal to the timeframe for standard resolution in accordance with Section 9 of this Contract, and

9.7.5.4.2 Make efforts to give the Medicaid Managed Care Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

**9.7.5.5 Failure to Make a Timely Decision**

9.7.5.5.1 Expedited Appeals shall be resolved no later than the above-stated time frames, and all parties shall be informed of the CONTRACTOR's decision. If a determination is not made within the above-stated time frames, the Medicaid Managed Care Member's request will be deemed approved as of the date upon which a final determination should have been made.

**9.8 Continuation of Benefits while the CONTRACTOR-Level Appeal and the State Fair Hearing are Pending**

**9.8.1 Terminology**

9.8.2 As used in this Section of this Contract, "timely" filing means filing on or before the later of the following:

9.8.2.1 Within ten (10) calendar days of the CONTRACTOR mailing the notice of Action.

9.8.2.2 The intended effective date of the CONTRACTOR's proposed Action.

**9.8.3 Continuation of Benefits**

9.8.3.1 The CONTRACTOR must continue the Medicaid Managed Care Member's benefits if:

9.8.3.1.1 The Medicaid Managed Care Member or the Provider files the Appeal timely;

9.8.3.1.2 The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

9.8.3.1.3 The services were ordered by an authorized Provider;

9.8.3.1.4 The original period covered by the original authorization has not expired; or

9.8.3.1.5 The Medicaid Managed Care Member requests extension of benefits.

9.8.4 **Duration of Continued or Reinstated Benefits**

9.8.4.1 If, at the Medicaid Managed Care Member's request, the CONTRACTOR continues or reinstates the Medicaid Managed Care Member's benefits while the Appeal is pending, the benefits must be continued until one of following occurs:

9.8.4.1.1 The Medicaid Managed Care Member withdraws the Appeal.

9.8.4.1.2 Ten (10) calendar days pass after the CONTRACTOR mails the notice providing the resolution of the Appeal against the Medicaid Managed Care Member, unless the Medicaid Managed Care Member, within the ten (10) day timeframe, has requested a State Fair Hearing with continuation of benefits until a decision is reached.

9.8.4.1.3 A State Fair Hearing Officer issues a hearing decision adverse to the Medicaid Managed Care Member.

9.8.4.1.4 The time period or service limits of a previously authorized service has been met.

9.8.5 **Medicaid Managed Care Member Responsibility for Services Furnished While the Appeal is Pending**

9.8.5.1 If the final resolution of the Appeal is adverse to the Medicaid Managed Care Member (i.e., the CONTRACTOR's Action is upheld), the CONTRACTOR may recover the cost of the services furnished to the Medicaid Managed Care Member while the Appeal was pending, to the extent that the services were furnished solely because of the requirements of this Section of this Contract and in accordance with the policy set forth in 42 CFR § 431.230(b).

9.8.5.2 The CONTRACTOR may not submit any encounters information related to the services appeal if it recoups the money from the Medicaid Managed Care Member.

**9.9 Grievance System Information**

9.9.1 The CONTRACTOR must provide the information specified at 42 CFR § 438.10(g)(1) about the Grievance system to all Providers and Subcontractor's at the time they enter into a contract with the CONTRACTOR.

**9.10 Effectuation of Reversed Appeal Resolutions**

9.10.1 **Services Not Furnished While Appeal is Pending**

9.10.1.1 If the CONTRACTOR or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the CONTRACTOR must authorize or provide the disputed services promptly, and as expeditiously as the Medicaid Managed Care Member's health condition requires.

**9.10.2 Services Furnished While Appeal is Pending**

9.10.2.1 If the CONTRACTOR or the State Fair Hearing Officer reverses a decision to deny authorization of services, and the Medicaid Managed Care Member received the disputed services while the Appeal was pending, the CONTRACTOR must pay for those services, in accordance with State policy and regulations.

**9.11 Provider Appeals System**

9.11.1 The CONTRACTOR shall establish a Provider Appeal System for in-network and out-of-network providers to dispute the CONTRACTOR's policies, procedures, or any aspect of the CONTRACTOR's administrative functions. At a minimum, the Provider Appeal System shall:

9.11.1.1 Have dedicated provider relations staff for providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a provider appeal and resolve problems;

9.11.1.2 Identify a staff person specifically designated to receive and process provider complaints;

9.11.1.3 For contracted providers, the appeals process shall address any adverse Action, including the denial or reduction of claims for services included on a clean claim;

9.11.1.4 For non-contracted providers the appeals process will address nonpayment, denial or reduction of a covered service rendered out of network including emergency care;

9.11.1.5 The appeal process shall not address a plan's decision to not contract with a provider, a plan's decision to terminate a contract with a provider, denials due to payment adjustments for National Correct Coding Initiative (NCCI), or services that are not covered under the contract;

9.11.1.6 Establish a process to thoroughly investigate each provider appeal using applicable statutory, regulatory, contractual and provider subcontract provisions, collecting all pertinent facts from all parties and applying the CONTRACTOR's written policies and procedures;

9.11.1.7 Ensure that individuals with the authority to require corrective action are involved in the provider appeal process;

9.11.1.8 The CONTRACTOR shall have and implement written policies and procedures that detail the operation of the Provider Appeal System; and

9.11.1.9 The CONTRACTOR shall submit its Provider Appeal System policies and procedures to Department for review and approval within ninety (90) Calendar Days of the date this Contract is signed.

9.11.2 The policies and procedures shall include, at a minimum:

9.11.2.1 Allowing providers thirty (30) calendar days from the receipt of notice of an adverse action to file a written appeal;

9.11.2.2 A description of how a provider may file an appeal with the CONTRACTOR for issues that are to be addressed by the Provider Appeal System and under what circumstances a provider may file an appeal directly to the Department for those decisions that are not a unique function of the CONTRACTOR;

9.11.2.3 A description of how provider relations staff are trained to distinguish between a provider appeal and a Medicaid Managed Care Member grievance or appeal in which the provider is acting on the Medicaid Managed Care Member's behalf;

9.11.2.4 For appeals related to denial of payment or reduction in payment, the process will provide for the following:

9.11.2.4.1 A process to allow providers to consolidate appeals of multiple claims that involve the same or similar payment issues, regardless of the number of individual patients or payment claims included in the bundled complaint;

9.11.2.4.2 Provide for different levels of appeals as follows:

9.11.2.4.2.1 Level I Appeal

9.11.2.4.2.1.1 The CONTRACTOR must investigate and render a decision regarding Level I Appeals within 30-business days of the request of the provider appeal.

9.11.2.4.2.2 Level II Appeal

9.11.2.4.2.2.1 To the extent the CONTRACTOR upholds the decision for all or part of the amount in dispute, the provider may request to proceed to a Level II Appeal.

9.11.2.4.2.2.2 Such request must be made within 30-days of the determination regarding the Level 2 Appeal.

9.11.2.4.2.2.3 The Level 2 Appeal must consist of an administrative review conducted by a supervisor and/or manager employed by the CONTRACTOR with the authority to revise the initial claims determination if needed.

9.11.2.4.2.2.4 A decision regarding the appeal must be provided within 30-business days of the request of the appeal.

9.11.2.4.2.2.5 To the extent additional information is required to render a decision on the appeal, the Contract may extend the time frame by fifteen (15) days based on mutual agreement of the Provider and the CONTRACTOR.

9.11.2.5 A process for thoroughly investigating each appeal using applicable sub-contractual provisions, and for collecting pertinent facts from all parties during the investigation;

9.11.2.6 A description of the methods used to ensure that CONTRACTOR's executive staff with the authority to require corrective action are involved in the appeal process, as necessary;

9.11.2.7 A process for giving providers (or their representatives) the opportunity to present their cases in person;

9.11.2.8 Identification of specific individuals who have authority to administer the provider appeal process;

9.11.2.9 A system to capture, track, and report the status and resolution of all provider complaints, including all associated documentation. This system must capture and track all provider complaints, whether received by telephone, in person, or in writing; and A provision requiring the CONTRACTOR to report the status of all provider complaints and their resolution to Department on a monthly basis in the format required by Department.

## **10 THIRD PARTY LIABILITY**

### **10.1 General**

- 10.1.1 Medicaid is the payer of last resort and pays for covered services only after any other sources have paid. Federal law requires South Carolina to have in place processes and procedures to identify third parties liable for payment of services under the South Carolina State Plan for Medical Assistance and for payment of claims involving third parties. See S.C. Code Ann. § 43-7-410 et seq (Supp. 2011, as amended) for definitions and statutory requirements.
- 10.1.2 Federal law considers the program outlined in the South Carolina statute and the federal regulations to be the Third Party Liability (TPL) program. This involves identification of other payers, including, but not limited to, group health and other health insurers, Medicare, liability insurance and workers' compensation insurance.
- 10.1.3 In accordance with federal law, South Carolina state law considers all Medicaid Recipients, including Medicaid Managed Care Members, to have assigned to the Department their rights to payment or recovery from a third party or private insurer. State law also requires that Medicaid Recipients cooperate with the Department in the enforcement of these assigned rights. Failure to cooperate with the Department violates the conditions for eligibility and may result in the recipient's loss of Medicaid eligibility. South Carolina law also subrogates the Department to the Medicaid Recipient's right to recover from a third party.

## **10.2 Department Responsibilities**

- 10.2.1 The Department will be responsible for maintaining the contract(s) needed for insurance verification services or to identify third party coverage for all Medicaid beneficiaries, regardless of the health care service delivery system.
- 10.2.2 The Department will provide data to the CONTRACTOR regarding any third-party insurance coverage for any covered Medicaid Managed Care Member in the CONTRACTOR's Health Plan.
- 10.2.3 While the Department will make reasonable efforts to ensure accuracy of shared data, the Department cannot guarantee the accuracy of the data. (See the Managed Care Policy and Procedure Manual).

## **10.3 CONTRACTOR Responsibilities**

- 10.3.1 The CONTRACTOR is responsible for administering the TPL program requirements in accordance with Section 1902(a)(25) of the Social Security Act and 42 CFR § 433 Subpart D, as they apply to services provided under this Contract to Medicaid Managed Care Members.
- 10.3.2 The CONTRACTOR:
- 10.3.2.1 Shall coordinate benefits in accordance with 42 CFR § 433.135 and Department requirements published in the Managed Care Policy and Procedure Manual.

- 10.3.2.2 Must implement cost avoidance and post-payment recovery procedures in accordance with federal and State requirements.
- 10.3.2.3 Is also required to take reasonable measures to identify any legally liable third party insurance coverage for its Medicaid Managed Care Members. This includes both health insurance coverage (including government payers such as Medicare and TriCare) and casualty insurance coverage.
- 10.3.2.4 Must adjudicate the claim and use post-payment recovery if the probable existence of Third Party Liability (TPL) was not established by either the CONTRACTOR or the Department prior to submission of the claim.

#### **10.4 Cost Avoidance**

- 10.4.1 In accordance with Department requirements in the Managed Care Policy and Procedure Manual, the CONTRACTOR must have processes, methods and resources necessary to receive TPL data from the Department and to identify third-party coverage for its members. This information will be used in managing provider payment at the front end before the claim is paid. The CONTRACTOR must have appropriate edits in the claims system to ensure that claims are properly coordinated when other insurance is identified. The CONTRACTOR's Medicaid reimbursement and third party payment cannot exceed the amount the provider has agreed to accept as payment in full from the third party payer.
- 10.4.2 If the probable existence of TPL has been established at the time the claim is filed, the CONTRACTOR must reject the claim and return it to the provider for a determination of the amount of any TPL.
- 10.4.3 The CONTRACTOR shall bill or inform the provider to bill the third-party coverage within thirty (30) days of identification.
- 10.4.4 For certain services, the CONTRACTOR should not cost-avoid claims and will pursue recovery under a policy known as "Pay & Chase". See the Managed Care Policy and Procedure Manual for list of services. While providers of such services are encouraged to file with any liable third party before the CONTRACTOR, if they choose not to do so, the CONTRACTOR will pay the claims and bill liable third parties directly through a Benefit Recovery program.
- 10.4.5 The CONTRACTOR shall deny payment on a claim that has been denied by a known third party payer, as defined in Section 10, when the reason for denial is the provider or Medicaid Managed Care Member's failure to follow prescribed procedures, including but not limited to, failure to obtain prior authorization, timely filing, etc.

#### **10.5 Post-Payment Recoveries**

10.5.1 Post-payment recovery is necessary in cases where the CONTRACTOR has not established the probable existence of a liable third party at the time services were rendered or paid for, for members who become retroactively eligible for Medicare, or in situations when the CONTRACTOR was unable to cost-avoid.

10.5.2 The CONTRACTOR must have procedures in place to ensure that a provider who has been paid by the CONTRACTOR and subsequently receives reimbursement from a third party repays the CONTRACTOR either the full amount paid by Medicaid or the full amount paid by the third party, whichever is less.

### 10.5.3 **CONTRACTOR Post-Payment Recovery Requirements**

10.5.3.1 In accordance with Department requirements in the Managed Care Policy and Procedure Manual, the CONTRACTOR must have established procedures for recouping post-payment. The procedures must be available for review upon request by the Department.

10.5.3.2 The CONTRACTOR must void encounters for claims that are recouped in full.

10.5.3.3 The CONTRACTOR will submit a replacement encounter for recoupments that result in an adjusted claim value.

10.5.3.4 The CONTRACTOR shall seek reimbursement in accident/trauma-related cases when claims in the aggregate equal or exceed \$250.

10.5.3.5 The CONTRACTOR shall report all recoveries it collects outside of the claims processing system, including settlements. The CONTRACTOR shall treat such recoveries as offsets to medical expenses for the purposes of reporting.

### **10.6 Retroactive Eligibility for Medicare**

10.6.1 The CONTRACTOR must immediately report to the Department any members who become retroactively eligible for Medicare and refund any PMPM payments paid by the Department for the time period of the member's retroactive eligibility.

### **10.7 Third-Party Liability Reporting Disenrollment Requests**

10.7.1 The CONTRACTOR must submit a disenrollment request if it has identified the presence of third party resource that results in the individual's being ineligible for enrollment in CONTRACTOR's Health Plan.

10.7.2 If, after the CONTRACTOR makes all reasonable efforts to obtain Medicaid Managed Care Member cooperation, a Medicaid Managed Care Member refuses to cooperate with the CONTRACTOR in pursuit of liable third parties, the CONTRACTOR will consult with the Department.

## **10.8 Third-Party Liability Recoveries by the Department**

- 10.8.1 After one hundred and eighty (180) days from the date of payment of a claim subject to recovery, the Department reserves the right to attempt recovery independent of any action by the CONTRACTOR.
- 10.8.2 The Department will retain all funds received as a result of any state-initiated recovery or subrogation action.

## **10.9 Reporting Requirements**

10.9.1 The CONTRACTOR shall report all third-party cost-avoidance and recoveries for its Medicaid Managed Care Members as outlined below and in accordance with the format specified in the Managed Care Policy and Procedure Manual.

10.9.2 The CONTRACTOR shall provide a monthly submission of TPL recoveries.

10.9.2.1 The CONTRACTOR's submission must:

10.9.2.1.1 Inform the Department of the probable existence of third party coverage that is not known to the Department and any change or lapse in the Medicaid Managed Care Member's third party insurance coverage of which the CONTRACTOR has notice.

10.9.2.1.2 Specify the amounts cost-avoided and amounts collected post-payment through retro recovery process.

10.9.2.1.3 For any third party recoveries collected after the reporting period for encounter data, the CONTRACTOR shall report this information to the Department and revise the next submission of the encounter data report to either void or adjust the encounter as appropriate.

10.9.2.1.4 The CONTRACTOR shall be required to include the collections and claims information in the encounter data submitted to the Department, including any retrospective findings via encounter adjustments.

## **11 PROGRAM INTEGRITY**

### **11.1 General**

#### **11.1.1 Department Requirements**

11.1.1.1 The State Medicaid agency is responsible for protecting the integrity of the Medicaid program, regardless of the service delivery system. To this end, the Department and its respective Divisions engage in activities designed to protect the integrity of the Medicaid program and identify, prevent and recover losses from waste, fraud, and abuse.

11.1.1.2 Such activities include but are not limited to managing the fraud and abuse hotline, receiving complaints and tips about suspected Medicaid fraud and abuse, conducting audits and investigations of individual health care providers, facilities, and suppliers and Medicaid beneficiaries, identifying and recovering for overpayments and inappropriate utilization of benefits, making referrals to external law enforcement and regulatory agencies, and managing provider sanctions including exclusions and terminations for cause.

**11.1.2 CONTRACTOR Requirements**

11.1.2.1 The CONTRACTOR shall have surveillance and utilization control programs and procedures in accordance with 42 CFR §§ 456.3, 456.4, and 456.23 to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments.

11.1.2.2 The CONTRACTOR shall also establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall comply with all state and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, §§. 1128, 1902, 1903, and 1932; 42 CFR §§ 431, 433, 434, 435, 438, 441, 447, 455; and 45 CFR Part 74.

**11.2 CONTRACTOR Program Integrity and Compliance Programs**

11.2.1 The CONTRACTOR must have administrative and management arrangements or procedures, including a written compliance plan, that are designed to guard against fraud and abuse.

11.2.2 The CONTRACTOR shall submit the compliance plan to the Department Division of Program Integrity as follows:

11.2.2.1.1 A paper and electronic copy of the plan shall be provided ninety (90) calendar days after execution of the contract and annually thereafter.

11.2.2.1.2 The Division of Program Integrity shall provide notice of approval, denial, or modification to the CONTRACTOR within sixty (60) calendar days of receipt.

11.2.2.1.3 The CONTRACTOR shall respond to request for modifications within twenty-one (21) business days.

11.2.2.1.4 The CONTRACTOR shall provide any modification to the compliance plan sixty (60) calendar days prior to the proposed effective date.

11.2.2.1.5 At a minimum the Compliance Plan must address the following in a format established by the Department and published in the Managed Care Policy and Procedure Guidelines:

11.2.2.1.5.1 Written policies, procedures, and standards of conduct that articulate the CONTRACTOR's commitment to comply with all applicable Federal and State standards and regulations;

11.2.2.1.5.2 The designation and identification of a compliance officer that is accountable to senior management; and

11.2.2.1.5.3 Establishment of a compliance committee that is accountable to senior management. The Compliance Committee shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive officials with the authority to commit resources. The Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.

11.2.2.2 Pursuant to the Deficit Reduction Act of 2005 (DRA), written policies for employees detailing:

11.2.2.2.1 The Federal False Claims Act provisions;

11.2.2.2.2 The administrative remedies for false claims and statements;

11.2.2.2.3 Any state laws relating to civil or criminal penalties for false claims and statements;

11.2.2.2.4 The whistleblower protections under such laws.

11.2.2.3 Effective training and education for the compliance officer and the organization's employees and subcontractor's. The training must comply with requirements of § 6032 of the Federal Deficit Reduction Act of 2005.

11.2.2.4 Effective lines of communication between the compliance officer and the CONTRACTOR's employees, subcontractors, and providers.

11.2.2.5 Enforcement of standards for the CONTRACTOR's own employees through well-publicized disciplinary guidelines.

11.2.2.6 Outline activities proposed for the next reporting year regarding employee education of federal and state laws and regulations related to Medicaid Program Integrity against Fraud/Abuse/Waste to ensure that all of its officers, directors, managers and employees know and understand the provisions of the CONTRACTOR's fraud and abuse compliance plan.

- 11.2.2.7 Provisions for internal monitoring and auditing which provide for independent review and evaluation of the CONTRACTOR's accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable federal and state laws and regulations.
- 11.2.2.8 Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to this Contract.
- 11.2.2.9 Provisions regarding provider reviews and audits consistent with Managed Care Policy and Procedure Manual.
- 11.2.3 The CONTRACTOR must outline activities for provider education of federal and state laws and regulations related to Medicaid Program Integrity (PI), and how it will identify and educate providers targeted for patterns of incorrect billing practices and/or overpayments;
- 11.2.4 The CONTRACTOR must require, through documented policies and subsequent contract amendments, that providers train their staff on the same aspects of the Federal False Claims Act provisions.
- 11.2.5 Provisions for notifying the Department of any CMS compliance issues related to HIPAA transaction and code set complaints or sanctions.
- 11.2.6 The Compliance Plan shall include a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, such as:
- 11.2.6.1 A list of automated pre-payment claims edits designed to ensure proper payment of claims and prevent fraudulent claims;
- 11.2.6.2 Internal operating procedures for desk audits or post-processing review of claims;
- 11.2.6.3 A list of reports of provider profiling and credentialing used to aid program and payment integrity reviews;
- 11.2.6.4 A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;
- 11.2.6.5 A list of references in provider and member material regarding fraud and abuse referrals;
- 11.2.6.6 A list of provisions for the confidential reporting of plan violations to the designated person;
- 11.2.6.7 Methods to ensure that the identities of individuals reporting violations of the CONTRACTOR are protected and that there is no retaliation against such persons;

11.2.6.8 Specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating fraud and abuse compliance plan violations.

11.2.7 The Compliance Plan must describe the CONTRACTOR's process for conducting monthly comparison of its provider files, including atypical providers, against the Excluded Parties List System (EPLS), the HHS-OIG List of Excluded Individuals/Entities (LEIE) and the Department list of state-excluded providers. This must also include a description of the CONTRACTOR's process for performing a monthly check for exclusions of its owners, agents and managing employees. Such processes must be consistent with the Managed Care Policy and Procedure Manual. The CONTRACTOR shall make available to the Department the summary of findings from the monthly check.

11.2.8 The compliance plan must also outline the CONTRACTOR's policies, procedures, and performance measures for the following program integrity and audit functions, including but not limited to:

11.2.8.1 Data mining to identify waste, fraud, and abuse

11.2.8.2 Provider audits

11.2.8.3 Audits conducted by a recovery audit CONTRACTOR

11.2.8.4 Quality assurance/utilization reviews of hospital providers

11.2.8.5 Pharmacy audits or reviews, if conducted by the CONTRACTOR and or its Pharmacy Benefits Manager (PBM) on the CONTRACTOR's behalf, to determine compliance with the Plan's pharmacy benefits program

11.2.9 The CONTRACTOR must publish the Department fraud hotline and fraud email address and toll-free line in all employee handbooks, provider manuals, and member communications and website.

11.2.9.1 The information must be placed in a prominent position so that members may easily identify the information in the materials.

**11.2.10 Employment of Personnel**

11.2.10.1 The CONTRACTOR shall have adequate staffing and resources needed to fulfill the Program Integrity and Compliance requirements of this contract; to investigate all reported incidents; and to develop and implement the necessary systems and procedures to assist the CONTRACTOR in preventing and detecting potential fraud and abuse activities.

11.2.10.2 The Compliance Plan and organizational chart must designate for Department approval the names and job functions for all CONTRACTOR staff involved in program integrity and other activities designed to identify fraud and abuse.

### **11.3 CONTRACTOR Subcontracting Review and Approval Procedures**

- 11.3.1 If the CONTRACTOR subcontracts for program integrity/surveillance and utilization review activities related to fraud and abuse detection and monitoring, including but not limited to data mining, auditing, and preliminary investigations for potential fraud and abuse by service providers, the CONTRACTOR shall file the following with the Division of Program Integrity (PI) for approval at least sixty (60) calendar days before subcontract execution:
- 11.3.1.1 The names, addresses, telephone numbers, email addresses, and fax numbers of the principals of the entity with which the CONTRACTOR plans to or has a subcontract with;
  - 11.3.1.2 A description of the qualifications of the principals of the entity with which the CONTRACTOR plans to or has a subcontract with; and
  - 11.3.1.3 The proposed subcontract.
- 11.3.2 The CONTRACTOR shall submit to PI such executed subcontracts, attachments, exhibits, addendums or amendments thereto, within thirty (30) calendar days after execution.
- 11.3.3 The CONTRACTOR, as well as its subcontractors and providers, whether contract or non-contract, shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting.

### **11.4 Provider Review, Investigation, and Fraud/Abuse Reporting Requirements**

- 11.4.1 The CONTRACTOR must immediately report to the Department any suspicion or knowledge of fraud and abuse by its Medicaid Managed Care Members, employees, or subcontractors.
- 11.4.1.1 Such reports include but are not limited to, the false or fraudulent filings of claims, the acceptance or failure to return monies allowed or paid on claims known to be fraudulent, etc. See the Managed Care Policy and Procedure Guidelines for additional guidance.
- 11.4.2 The CONTRACTOR must report the fraud referral to the Division of Program Integrity (PI) within one (1) business day, using either the Fraud Hotline or the Fraud email address.
- 11.4.3 The CONTRACTOR shall also complete the Fraud Reporting Form and send the completed form to the Program Integrity Director as soon as possible after the referral is made but no later than 10 business days after the referral.
- 11.4.3.1 The form will document the results of the CONTRACTOR's preliminary investigation.

- 11.4.4 Unless prior approval is obtained from the Department, after reporting the suspected fraud and/or abuse, the CONTRACTOR shall suspend its investigation and not take any of the following actions as they specifically relate to Medicaid managed care claims:
- 11.4.4.1 Request medical records or contact the subject of the allegation;
  - 11.4.4.2 Enter into or attempt to negotiate any settlement or agreement regarding the incident;
  - 11.4.4.3 Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident;
  - 11.4.4.4 Alter or allow alteration of any claims that are part of an investigation.
- 11.4.5 Regardless of the fraud referral to the Department, the CONTRACTOR has the discretion to put a provider suspected of fraud or abuse on pre-payment review or otherwise take preventative actions as necessary to prevent further loss of funds.
- 11.4.6 The CONTRACTOR and the Department's Division of Program Integrity will collaborate on provider program integrity reviews as much as possible.
- 11.4.6.1 The collaboration may involve data sharing and joint review of providers that provide Medicaid services in both fee-for-service (FFS) and managed care environments.
- 11.4.7 The CONTRACTOR will provide any information needed by Program Integrity for provider reviews, including but not limited to copies of provider subcontracts, provider manuals, policies and procedures, all fee schedules, and credentialing files.
- 11.4.8 The CONTRACTOR will coordinate with the Department for provider or member complaints received from the fraud hotline or email, as directed in the Policy and Procedures Guidelines.
- 11.4.8.1 If a member is referred for suspicion of fraud or abuse, the CONTRACTOR is under no further obligation to investigate or open a case.
  - 11.4.8.2 Member fraud is pursued entirely by the Department in conjunction with the South Carolina State Attorney General's Office under specific contractual provisions.
- 11.4.9 The CONTRACTOR shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal.

11.4.9.1 Such cooperation shall include providing, immediately upon request, information, access to records, access to automated payment and information management systems, access to proprietary fee schedules, and access to interview CONTRACTOR employees and consultants, including but not limited to those with expertise in the administration of the program and/or in medical or pharmaceutical questions or in any matter related to an investigation.

11.4.10 Upon notification by the Department of a credible allegation of fraud pursuant to 42 CFR § 455.23, the CONTRACTOR must suspend payments to contracted providers and/or administrative entities involved.

11.4.11 If the CONTRACTOR fails to suspend provider payments in cases of credible allegation of fraud notification from the Department pursuant to 42 CFR § 455.23, the Department shall have the right to withhold from a CONTRACTOR's capitation payments an appropriate amount.

### **11.5 Recoveries and Provider Refunds**

11.5.1 In the event that the Department, either from restitutions, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil monetary penalty, a global civil settlement or judgment, or any other form of civil action, receives a monetary recovery from an entity, the entirety of such monetary recovery belongs exclusively to the Department and the CONTRACTOR has no claim to any portion of this recovery.

11.5.1.1 Furthermore, the CONTRACTOR is fully subrogated to the Department for all criminal and civil recoveries.

11.5.2 The Department shall have the right to recover directly from providers and Medicaid Managed Care Members in the CONTRACTOR's network for the audits and investigations that the Department conducts.

11.5.2.1 Such recoveries by the Department shall not be shared with the CONTRACTOR.

11.5.3 When directed by the Department, the CONTRACTOR shall withhold payment to a provider as warranted for recoupment.

11.5.3.1 The Contract shall send the Department the money withheld from a provider based upon this provision and provide reports in a format directed by the Department.

11.5.4 The Department shall retain all recoveries/penalties/civil settlements resulting from fraud and abuse cases pursued by the Department and/or the MFCU, after the MFCU deducts its fees and costs as appropriate.

- 11.5.5 The Department shall be responsible for establishing administrative procedures for recovering funds from managed care providers and for ensuring that the federal share of any recoveries is reported in accordance with CMS requirements.
- 11.5.5.1 Any funds recovered and retained by the Department will be reported to the CONTRACTORS involved as well as to the actuary to consider in the rate-setting process.
- 11.5.6 The Department shall notify the CONTRACTOR when it identifies an overpayment made to the CONTRACTOR.
- 11.5.6.1 Should the CONTRACTOR become aware of an overpayment it is responsible for reporting the identification and the estimated amount of the overpayment within 30 business days of discovery.
- 11.5.7 The CONTRACTOR agrees that all amounts identified as being owed to the Department are due immediately upon discovery and/or notification unless otherwise authorized in writing by the Department.
- 11.5.8 The Department reserves the right to collect interest on unpaid balances beginning thirty (30) calendar days from the date of initial notification to the CONTRACTOR and after sixty (60) days upon notification to a provider.
- 11.5.8.1 The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR § 30.13.
- 11.5.8.2 This rate may be revised quarterly by the Secretary of the Treasury and shall be published by HHS in the Federal Register.
- 11.5.9 The Department reserves the right to collect any amount owed to the Department as a result of, including but not limited to, audits, overpayments, errors in payment, penalties, and liquidated damages, by deducting the amount owed from the next monthly capitation payment due to the plan.
- 11.5.10 The CONTRACTOR shall reimburse the Department for any federal disallowances or sanctions imposed on the Department as a result of the CONTRACTOR's failure to abide by the terms of the Contract.
- 11.5.11 The CONTRACTOR will be subject to any additional conditions or restrictions placed on the Department by the United States Department of Health and Human Services (HHS) as a result of the disallowance.
- 11.5.12 The CONTRACTOR shall provide any information from encounter data, data from its claims processing and financial systems, or other data regarding Medicaid benefits paid on behalf of its members, as needed by the Department, SC State Attorney General's Office, or as otherwise directed by the Department in pursuing any litigation or settlements.

- 11.5.13 This includes information from the CONTRACTOR's Pharmacy Benefits Manager.
- 11.5.14 The CONTRACTOR shall have the right to recover directly from providers and Medicaid Managed Care Members in the CONTRACTOR's network for the audits and investigations the CONTRACTOR conducts that do not involve fraud or abuse.
- 11.5.15 Funds recovered and retained by the CONTRACTOR due to its own audit and compliance programs, including funds recovered through the use of a recovery audit CONTRACTOR, must be reported to the Department as prescribed in the Managed Care Policy and Procedures Guidelines.

### **11.6 Reporting Requirements for Program Integrity**

- 11.6.1 The CONTRACTOR must submit a Monthly Fraud and Abuse Activities Report, in the form and manner established in the Managed Care Policy and Procedures Guidelines and Operating Companion Guide.
- 11.6.2 The CONTRACTOR must submit a monthly TIPS Report to include any audit or review of a provider for allegations of provider error in the form and manner established in the Managed Care Policy and Procedures Guidelines and Operating Companion Guide.
- 11.6.3 The CONTRACTOR must submit a Quarterly Fraud and Abuse Report that will be based on the monthly reports and show outcomes or results of the CONTRACTOR's program integrity efforts.
- 11.6.3.1 This will include the amount of overpayments recovered and whether the CONTRACTOR had applied any sanctions to providers as a result of Program Integrity activities.
- 11.6.3.2 The Quarterly Fraud and Abuse Report will be in the form and manner established in the Managed Care Policy and Procedures Guidelines and Operating Companion Guide.
- 11.6.4 All Program Integrity reports must be sent to the Department's Division of Program Integrity (PI) through the secure portal or by e-mail from the CONTRACTOR.
- 11.6.5 The Monthly Fraud and Abuse Activities and the TIPS Report are due on the 15th of the following month. (For example, January data will be reported on the February 15th report).
- 11.6.5.1 The Quarterly Fraud and Abuse Report is due no later than fifteen (15) calendar days after the end of each quarter (April 15th; July 15th; October 15th; and January 15th).

### **11.7 Ownership and Control**

11.7.1 The CONTRACTOR shall provide the Department with full and complete information on the identity and address of each person or corporation with an ownership or control interest as described in 42 CFR 455.101 (2010, as amended), including officers, directors and partners and persons with direct and/or indirect ownership interests (mortgage, deed of trust, note or other obligation secured by the disclosing entity) totaling five percent (5%) or more in the Health Plan, or any Subcontractor in which the Contactor has a five percent (5%) or more ownership interest in accordance with 42 CFR § 455 (2010, as amended).

11.7.1.1 This information shall be provided to the Department on the approved Disclosure of Ownership and Control Interest Statement and updated whenever changes in ownership occur.

### **11.8 CONTRACTOR Providers and Employees - Exclusions, Debarment, and Terminations**

11.8.1 The CONTRACTOR agrees to comply with all applicable provisions of 2 CFR Part 376 (2009, as amended) pertaining to debarment and/or suspension for all its employees, subcontractors, and all providers.

11.8.2 The CONTRACTOR is subject to and agrees to comply with all applicable provisions of 42 CFR Part 1001. This applies to providers who render, prescribe, order or refer services to Medicaid members. Federal regulations preclude reimbursement for any services ordered, prescribed, or rendered by a provider who is currently excluded or terminated from direct and indirect participation in the South Carolina Medicaid program or federal Medicare program.

11.8.2.1 A Medicaid Managed Care Member may purchase services provided, ordered, or prescribed by a suspended or terminated provider, but no Medicaid funds nor Medicaid capitated payments from the CONTRACTOR can be used.

11.8.3 Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.

11.8.3.1 This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription.

11.8.4 Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries (See Section 1128A(a)(6) of the Social Security Act and 42 CFR § 1003.102(a)(2)).

- 11.8.5 The CONTRACTOR must ensure that its provider networks do not include any provider, whether an individual or entity, that has been excluded, debarred or suspended from participation in Medicare, Medicaid, the State Children's Health Insurance Program, and/or any other federal health care programs.
- 11.8.6 The CONTRACTOR shall establish an electronic database to capture identifiable information on the owners, agents and managing employees listed on providers' Disclosure forms.
- 11.8.7 The CONTRACTOR must screen all Providers and Subcontractors to determine whether they have been excluded or debarred from participation in Medicare, Medicaid, the State Children's Health Insurance Program, and/or all federal health care programs, through the following mechanisms:
- 11.8.7.1 The CONTRACTOR should search the List of Excluded Individuals and Entities (LEIE) website located at <https://oig.hhs.gov/exclusions/index.asp>.
- 11.8.7.2 The CONTRACTOR should also search the Department's list of providers who are terminated, suspended, or otherwise excluded from participation in the Medicaid program, available on the Department's website.
- 11.8.7.3 The CONTRACTOR should search the "System for Award Management" (formerly the Excluded Parties List Service) administered by the General Services Administration.
- 11.8.7.4 The CONTRACTOR will conduct a search of these websites monthly to capture exclusions and reinstatements that have occurred since the last search.
- 11.8.7.5 The CONTRACTOR shall provide a monthly electronic record of all searches it is required to conduct monthly.
- 11.8.7.6 The CONTRACTOR shall report to the Department any network Providers or Subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery.
- 11.8.8 Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or SCHIP except for emergency services.
- 11.8.9 The CONTRACTOR must also ensure that it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other agreement with debarred individuals for the provision of items and services that are the CONTRACTOR's contractual obligation.
- 11.8.9.1 The CONTRACTOR must perform the same screening of employees and administrative subcontractors as required in Section 2 of this Contract.

11.8.10 Failure on the part of the CONTRACTOR to adhere to these provisions may result in liquidated damages and/or in sanctions, up to and including the termination of this contract.

### **11.9 Prohibited Affiliations with Individuals Debarred by Federal Agencies**

11.9.1 The CONTRACTOR must not knowingly have a relationship with an individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive order No. 12549 or under guidelines implementing Executive order No. 12549.

11.9.2 An individual who is an affiliate is defined as follows:

11.9.2.1 A director, officer, or partner of the CONTRACTOR;

11.9.2.2 A person with a beneficial ownership of five percent or more in the CONTRACTOR;

11.9.2.3 A person with an employment, consulting or other arrangement with the CONTRACTOR for the provision of items and services significant and material to the CONTRACTOR's obligations under its contract with the Department.

11.9.3 Non-compliance with this Section of this Contract will be reported to the HHS Secretary / OIG, and may result in the loss of this contract with the Department.

### **11.10 Provider Termination / Denial of Credentials**

11.10.1 The CONTRACTOR shall ensure that none of its Providers and Subcontractors have a Medicaid Contract with the Department that was terminated or denied for cause and/or suspended as a result of any action of the CMS of the U.S. Department of Health and Human Services, the Medicaid Fraud Unit of the Office of the South Carolina Attorney General, or the Department.

11.10.2 Providers who have been terminated by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and/or are currently under exclusion shall not be allowed to participate in the Medicaid Managed Care Program.

11.10.3 The CONTRACTOR is required to terminate Providers/Subcontractors for cause in accordance with federal regulations found at 42 CFR § 455.416 and Department policies, and to report these terminations in a manner determined by the Department.

11.10.4 The CONTRACTOR shall notify the Division of Program Integrity when the CONTRACTOR denies a provider credentialing application for program integrity-related reasons or otherwise limits the ability of providers to participate in the program for program integrity reasons.

### **11.11 Information Related to Business Transactions**

11.11.1 The CONTRACTOR agrees to furnish to the Department or to HHS information concerning significant business transactions as set forth in 42 CFR § 455.105 (2010, as amended).

11.11.2 Failure to comply with this requirement may result in termination of this Contract.

11.11.3 The CONTRACTOR also agrees to submit, within thirty-five (35) calendar days of a request from the Department, full and complete information about:

11.11.4 The ownership of any Subcontractor with whom the CONTRACTOR has had business transactions totaling more than \$25,000 during the twelve (12) month period ending on the date of this request; and

11.11.5 Any significant business transactions between the CONTRACTOR and any wholly owned supplier, or between the CONTRACTOR and any Subcontractor, during the five-year period ending on the date of this request.

11.11.6 For the purpose of this Contract, “significant business transactions” means any business transaction or series of transactions during any of the fiscal year that exceed the \$25,000 or 5% of the CONTRACTOR’s total operating expenses.

### **11.12 Information on Persons Convicted of Crimes**

11.12.1 The CONTRACTOR agrees to furnish to the Department or HHS information concerning any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106 (2010, as amended).

11.12.2 Failure to comply with this requirement may lead to termination of this Contract.

## **12 MARKETING PROGRAM**

### **12.1 General Marketing Requirements**

12.1.1 This Section of this Contract shall govern any and all communications by the CONTRACTOR to a current or potential Medicaid beneficiary, not currently enrolled in a managed care plan. In addition to the requirements stated herein, any and all Marketing materials and activities distributed or performed by the CONTRACTOR shall meet the requirements set forth in 42 CFR § 438.104 and the Department's Managed Care Policy and Procedure Guide.

### **12.2 Prior Approval of Marketing Materials**

12.2.1 The Department shall have final approval of all Marketing Materials regarding the Managed Care Program (aka Healthy Connections), prior to distribution by the CONTRACTOR.

12.2.2 The CONTRACTOR must submit any and all proposed Marketing Materials to the Department through its Department Liaison. (Further guidance regarding the format of and procedure for the submission of Marketing Materials to the Department can be found in the Department's Managed Care Policy and Procedure Guide.)

12.2.3 The Department agrees to respond to CONTRACTOR's request for approval of Marketing Materials within thirty (30) calendar days of submission and may approve, deny or require modification of submitted materials within thirty (30) days. If the Department fails to respond within thirty (30) calendar days, the CONTRACTOR may consider the request approved.

12.2.3.1 The Department reserves the right, in extraordinary circumstances, to extend the thirty (30) day deadline. The Department shall notify the CONTRACTOR of the reason for the extension and expected date of decision.

### **12.3 Guidelines for Marketing Materials and Activities**

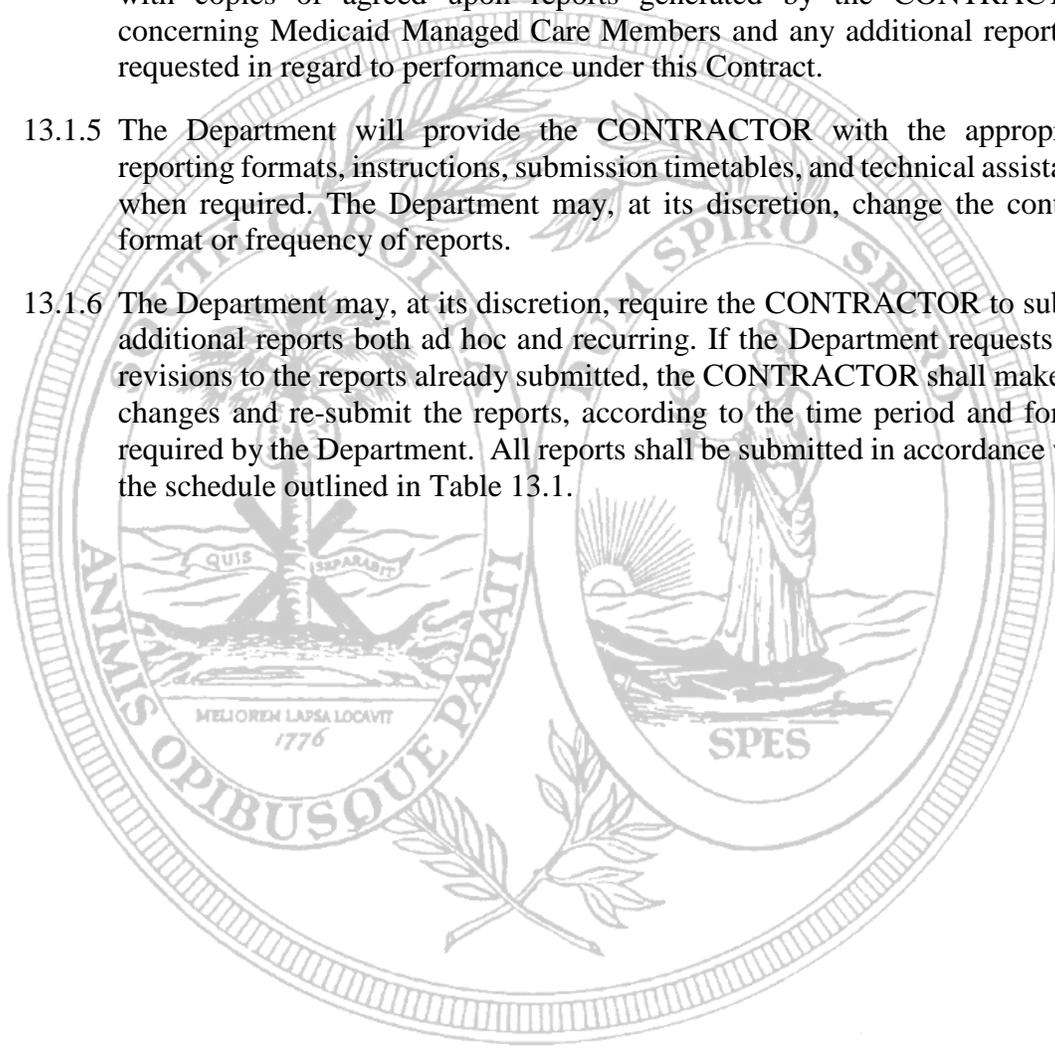
12.3.1 Pursuant to 42 CFR § 438.104(c), the Department's guidelines for appropriate Marketing Materials and Activities will be conducted in accordance with 42 CFR 438.104 and include consultation with the Medical Care Advisory Committee (MCAC) or an advisory committee with similar membership, as determined appropriate by the Department and in accordance with the Department's Managed Care Policy and Procedure Manual.

## **13 REPORTING REQUIREMENTS**

### **13.1 General Requirements**

13.1.1 The CONTRACTOR is responsible for complying with all of the reporting requirements established by Department.

- 13.1.2 The CONTRACTOR must connect using TCP/IP protocol to a specific port using ConnectDirect software after signing a Trading Partners Agreement as required by the Department's Information Technology area.
- 13.1.3 Connectivity must be verified by the Department in writing, and the CONTRACTOR shall provide the Department with a sample of all hard copy reports prior to Contract execution for prior approval.
- 13.1.4 The CONTRACTOR shall provide the Department and any of its designees with copies of agreed upon reports generated by the CONTRACTOR concerning Medicaid Managed Care Members and any additional reports as requested in regard to performance under this Contract.
- 13.1.5 The Department will provide the CONTRACTOR with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. The Department may, at its discretion, change the content, format or frequency of reports.
- 13.1.6 The Department may, at its discretion, require the CONTRACTOR to submit additional reports both ad hoc and recurring. If the Department requests any revisions to the reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, according to the time period and format required by the Department. All reports shall be submitted in accordance with the schedule outlined in Table 13.1.



**Table 13.1** Reporting Schedule by Deliverable and Submission Due Date

<b>DELIVERABLE</b>	<b>SUBMISSION DUE DATE</b>
Daily Reports	Within three (3) business days
Weekly Reports	Within three (3) business days
Monthly Reports	Within fifteen (15) calendar days
Quarterly Reports	Within fifteen (15) calendar days
Annual Reports	Within ninety (90) calendar days after the end of the year.
Ad Hoc/Additional Reports	Within three (3) business days from the date of request unless otherwise specified by the Department.

13.1.7 In the event there are no instances to report, the CONTRACTOR shall submit null reports.

13.1.8 The CONTRACTOR shall submit all reports electronically and in the manner and format prescribed by the Department and shall ensure that all reports are complete and accurate. The CONTRACTOR shall be subject to liquidated damages as specified in Section 18 of this Contract for reports determined to be late, incorrect, incomplete or deficient, or not submitted in the manner and format prescribed by the Department until all deficiencies have been corrected. Except as otherwise specified by the Department.

13.1.8.1 When applicable, the required reports must be comparable to the encounter data submitted to the Department for the same time frames.

**13.1.9 Claims Management Reporting**

13.1.9.1 The CONTRACTOR shall submit a monthly Claims Payment Accuracy Report. If the CONTRACTOR subcontracts for the provision of any covered services, and the subcontractor is responsible for processing claims, then the report shall include claims processed by the subcontractor.

**13.1.10 Confidentiality of Information**

13.1.10.1 Information the CONTRACTOR considers proprietary must be clearly identified as such by the CONTRACTOR at the time of submission.

13.1.10.2 Information may be designated as confidential but may not be withheld from the Department as proprietary.

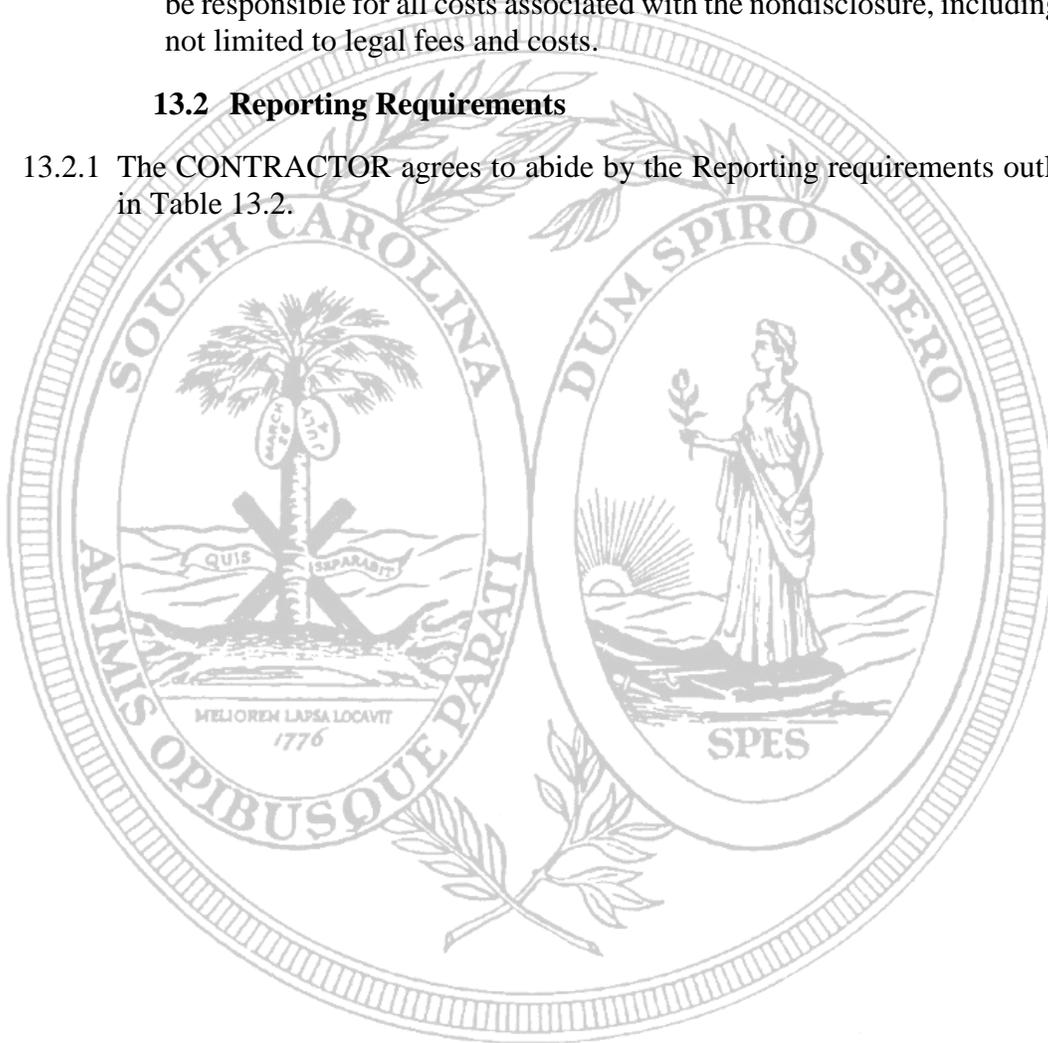
13.1.10.3 Information designated as confidential may not be disclosed by the Department without the prior written consent of the CONTRACTOR except as required by law.

13.1.10.4 If the CONTRACTOR believes the requested information is confidential and may not be disclosed to third parties, the CONTRACTOR shall provide a detailed legal analysis to the Department, within the timeframe designated by the Department, setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

13.1.10.5 In the event that the Department withholds information from a third party as a result of the CONTRACTOR's statement, the CONTRACTOR shall be responsible for all costs associated with the nondisclosure, including but not limited to legal fees and costs.

### **13.2 Reporting Requirements**

13.2.1 The CONTRACTOR agrees to abide by the Reporting requirements outlined in Table 13.2.



**Table 13.2.** Reporting Requirements, by Report, by Frequency, by Submission Due Date and Effective Date.

*(This Table is provided solely for convenience purposes and, in the event any information contained within this Table conflicts with a provision of this Contract, the Contract provision shall be controlling.)*



<b>REPORT</b>	<b>FREQUENCY</b>	<b>REPORT SUBMISSION DUE DATE</b>	<b>EFFECTIVE DATE† (MM/DD/YYYY)</b>
<b>2. CONTRACTOR Administrative Requirements</b>			
1) Training Plan	Annually	90 days after the end of a fiscal year	11/1/2014
<b>3. Eligibility and Enrollment</b>			
1) Call Center Performance Report	Monthly	15 calendar days from the end of the month	11/1/2014
<b>4. Services</b>			
1) Pharmacy Lock-in	Monthly & Quarterly	15 calendar days after the end of a period	11/1/2014
<b>5. Care Coordination</b>			
1) Care Management Report	Monthly	15 calendar days from the end of the month	11/1/2014
<b>6. Networks</b>			
1) Geographic Service Area Submissions	Bi-Annual	August 15 <sup>th</sup> , and February 15 <sup>th</sup>	07/1/2014
<b>7. Payments</b>			
1) Health Insurance Fee			
a) Certified copy of the CONTRACTOR's full Annual Fee Assessment	Annual	Within 60 days of date of notice from IRS	10/1/2014
2) FQHC/RHC Payments			

<b>REPORT</b>	<b>FREQUENCY</b>	<b>REPORT SUBMISSION DUE DATE</b>	<b>EFFECTIVE DATE† (MM/DD/YYYY)</b>
a) Quarterly payments	Quarterly	15 calendar days after the end of a quarter	10/1/2014
<b>9. Grievance &amp; Appeal Procedures</b>			
1) Grievance/Appeal Records & Reports			
a) All Grievances/Appeals filed by Medicaid Managed Care Members	Quarterly	15 calendar days after the end of a quarter	10/1/2014
2) Provider Appeals	Quarterly	15 calendar days after the end of a quarter	11/1/2014
<b>10. Third-Party Liability</b>			
• CONTRACTOR Post-Payment Recoveries	Monthly	The 15th day of the following month	11/1/2014
<b>11. Program Integrity</b>			
1) Monthly Fraud and Abuse Activities Report	Monthly	The 15th day of the following month	11/1/2014
2) Quarterly Fraud and Abuse Report	Quarterly	The 15th day following the close of each quarter	11/1/2014
3) TIPS Report	Monthly	The 15th day of the following month	11/1/2014
<b>13. Reporting Requirements</b>			
1) Claims Payment Accuracy	Monthly	The 15th day of the following month	10/1/2014
<b>14. Encounter Data</b>			

<b>REPORT</b>	<b>FREQUENCY</b>	<b>REPORT SUBMISSION DUE DATE</b>	<b>EFFECTIVE DATE† (MM/DD/YYYY)</b>
1) Encounter Data	Monthly	First business day following month end	10/1/2014
2) Security Audit	Biennial	By June 30, 2016	10/1/2014
3) Capitation Rate Calculation Sheet (CRCS)	Quarterly	Within 105 days of the end of each calendar quarter.	10/1/2014
4) Medical Loss Ratio (MLR)	Ad Hoc	Within the timeline specified within the Managed Care Policy and Procedure Manual.	10/01/2014
<b>15. Quality Assessment, Monitoring and Reporting</b>			
1) Quality Assessment & Performance Improvement	Annually	By June 15 <sup>th</sup> the following year	10/1/2014
2) External Quality Review	Annually	Various	10/1/2014
3) Member Satisfaction Survey	Annually	By June 15 <sup>th</sup> for previous calendar year	10/1/2014
4) HEDIS Reporting	Annually	By June 15 <sup>th</sup> for previous calendar year	10/1/2014
5) Value-Oriented Contracting	Annually & Ad Hoc	Within 3 business days of the date of request, unless otherwise specified by the Department.	01/1/2015
<b>Additional Reporting Requirements</b>			
1. All CONTRACTOR Policies and Procedures	Annually	Within 90 days of the end of the fiscal year	10/1/2014
2. Marketing Materials	Upon CONTRACTOR request	Upon CONTRACTOR request	10/1/2014

REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE	EFFECTIVE DATE† (MM/DD/YYYY)
Notes: †All reports shall include data from 07/01/2014			



## 14 ENCOUNTER DATA, REPORTING AND SUBMISSION REQUIREMENTS

### 14.1 General Data Requirements

14.1.1 The CONTRACTOR is required to exchange data with the Department relating to the information requirements of this contract and as required to support the data elements to be provided to the Department in accordance with 42 CFR § 438.242 and as specified in this Contract.

14.1.1.1 All data exchanged must be in the formats prescribed by the Department, which include those required/covered by the Health Insurance Portability and Accountability Act (HIPAA).

14.1.1.2 Details for the formats may be found in the HIPAA Transaction Companion Guides, Trading Partner Agreements, and the Department's Policy and Procedures, the Business Requirements Document for Technical Transition, and the CONTRACTOR ("MCO") Systems Guide, available on the Department's website.

14.1.2 The information reported to and exchanged with the Department shall be in accordance with all procedures, policies, rules, or statutes in effect during the term of this contract.

14.1.2.1 If any of these procedures, policies, rules, regulations or statutes are hereinafter changed, both parties agree to conform to these changes following notification by the Department.

14.1.2.2 The CONTRACTOR is responsible for complying with all of the reporting requirements established by Department and shall provide access to all collected data to the Department, its designees and to CMS upon request.

14.1.3 As required by 42 CFR 438.606, the CONTRACTOR shall certify all submitted data, documents and reports to be accurate, complete and truthful. The data that must be certified include, but are not limited to, all documents specified by the State, enrollment information, encounter data, and other information contained in contracts, proposals. The certification must attest, based on best knowledge, information, and belief as to the accuracy, completeness and truthfulness of the documents and data. The CONTRACTOR (MCO) must submit the certification concurrently with the certified data and documents.

14.1.3.1 This certification shall be made by one of the following:

14.1.3.1.1 The CONTRACTOR's Chief Executive Officer (CEO);

14.1.3.1.2 The CONTRACTOR's Chief Financial Officer (CFO); or

14.1.3.1.3 An individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO.

14.1.3.2 The certification shall be submitted concurrently with the certified data.

14.1.4 The CONTRACTOR shall specify to the Department the name of the primary contact person assigned responsibility for submitting and correcting Encounter Record, and a secondary contact person in the event the primary contact person is not available.

14.1.5 The CONTRACTOR is responsible for any incorrect data, delayed submission or payment (to the CONTRACTOR or its subcontractors), and/or penalty applied due to any error, omission, deletion, or erroneous insert caused by CONTRACTOR-submitted data.

14.1.5.1 Any data that does not meet the standards required by the Department shall not be accepted by the Department.

14.1.5.2 The CONTRACTOR further agrees to indemnify and hold harmless the State of South Carolina and the Department from any and all claims or liabilities, including but not limited to consequential damages, reimbursements or erroneous billings and reimbursements of attorney fees incurred as a consequence of any error, omission, deletion or erroneous insert caused by the CONTRACTOR in the submitted input data.

14.1.6 Neither the State of South Carolina nor the Department shall be responsible for any incorrect or delayed payment to the CONTRACTOR's providers (subcontractors) resulting from such error, omission, deletion, or erroneous input data caused by the CONTRACTOR in the submission of Medicaid claims.

14.1.7 The CONTRACTOR is also responsible for identifying any inconsistencies immediately upon receipt of data from the Department.

14.1.7.1 If any unreported inconsistencies are subsequently discovered, the CONTRACTOR shall be responsible for the necessary adjustments to correct its records at its own expense.

14.1.8 **Member Data:**

14.1.8.1 The CONTRACTOR shall accept from the Department original evidence of eligibility and enrollment in the Department prescribed electronic data exchange formats.

14.1.8.2 Upon request, the CONTRACTOR shall provide to Medicaid PCP assignments in an electronic data exchange format specified by the Department.

14.1.9 **Claims Data:**

14.1.9.1 The CONTRACTOR's system must be capable of collecting, storing and producing information for the purposes of financial, medical and operational management.

14.1.9.2 The CONTRACTOR shall develop and maintain a HIPAA compliant claims and encounter processing and payment system capable of processing, cost avoiding and paying claims in accordance with applicable South Carolina and Federal rules.

14.1.9.3 The system must be adaptable to updates in order to support future claims related policy requirements specified by the Department on a timely basis as needed.

**14.1.10 Electronic Transactions:**

14.1.10.1 The CONTRACTOR must be able to make claims payments via electronic funds transfer and have the capability to accept electronic claims attachments.

**14.1.11 Data Security:**

14.1.11.1 The CONTRACTOR is required to have a security audit performed by an independent third party on biennial (every two years) basis.

14.1.11.2 CONTRACTOR must have a security audit prior to June 30, 2016.

14.1.11.3 The biennial (every two years) audit report must be submitted to the Department, and must include, at a minimum: a review of CONTRACTOR policies and procedures to verify that appropriate security requirements have been adequately incorporated into the CONTRACTOR's business practices, and the production processing systems.

14.1.11.4 The audit must result in a findings report and as necessary a Corrective Action Plan (CAP), detailing all issues and discrepancies between the security requirements and the CONTRACTOR's policies, practices and systems. The corrective action plan must also include timelines for corrective actions related to all issues or discrepancies identified, and be submitted to the Department for review and approval.

14.1.11.4.1 The Department will verify that the required audit has been completed and the approved corrective action plan is in place and being followed as part of Operational Reviews.

**14.2 Encounter Data**

14.2.1 The CONTRACTOR must submit 100% of its encounter/claim data to Department for every service rendered to a member that resulted in either a paid or clinically denied claim.

14.2.1.1 The CONTRACTOR encounter submission must be at least 97% accurate upon initial submission.

14.2.1.1.1 Claims for services eligible for processing by the CONTRACTOR where no financial liability was incurred, including services provided during prior period coverage (i.e., zero paid claims) must also be included in encounter data.

14.2.1.1.2 Any item(s) or service(s) provided through Medicaid under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS and the Department, including non-fee-for-service payments based with quality such as bundled payments, partial capitation, fully capitated payments, and/or global rates designed to promote value-based purchasing.

14.2.1.1.3 “Clinically Denied” payments in this Section of this Contract mean any claim submitted by the provider to the CONTRACTOR that was denied for non-administrative reasons. Clinical Denial does not include claims that are rejected by the CONTRACTOR’s claims processing system because of incorrect submission, missing data elements, or other reasons that caused it not to be a “clean” claim.

14.2.2 The Encounter Record will be utilized by the Department for the following:

14.2.2.1 To evaluate access to health care, availability of services, quality of care and cost effectiveness of services;

14.2.2.2 To evaluate contractual performance;

14.2.2.3 To validate required reporting of utilization of services;

14.2.2.4 To develop and evaluate proposed or existing Capitation Rates;

14.2.2.5 To meet CMS Medicaid reporting requirements, including Transformed Medicaid Statistical Information System (TMSIS); and

14.2.2.6 For any purpose the Department deems necessary.

14.2.3 This record must incorporate HIPAA security, privacy, and transaction standards and be submitted in the American National Standards Institute (ANSI) ASC X12N 837 format or any successor format.

14.2.4 The CONTRACTOR must submit encounters in the format prescribed by the Department.

14.2.4.1 The HIPAA compliant transaction format and data elements and required format are identified in the Managed Care Policy and Procedure Manual and the Companion Guide.

- 14.2.4.2 The CONTRACTOR shall submit encounter data according to standards and formats as defined by the Department, complying with standard code sets and maintaining integrity with all reference data sources including provider and member data. Required standard transactions include:
- 14.2.4.2.1 ANSI ASC X12N 837 Health Care Claims (837P) transaction for professional claims and/or encounters.
  - 14.2.4.2.2 ANSI ASC X12N 837 Health Care Claims (837I) transaction for Institutional claims and/or encounters.
  - 14.2.4.2.3 National Council for Prescription Drug Program claims (NCPDP)- transaction for prescription drug claims.
  - 14.2.4.2.4 277CA – Claim acknowledgement receipt transaction
  - 14.2.4.2.5 999- Acknowledgement of claim transaction receipt
  - 14.2.4.2.6 All required File Transfer protocols and associated batch jobs
- 14.2.5 The CONTRACTOR shall adhere to federal and/or Department payment rules in the definition and treatment of certain data elements, e.g., units of service that are standard fields in the encounter data submissions and will be treated similarly by the Department across all CONTRACTORS.
- 14.2.6 The CONTRACTOR shall report the National Provider Identifier (NPI) for all of its providers (participating or non-participating), who are covered entities or health care providers and eligible to receive an NPI, on all claims and encounter data submitted to the Department. The CONTRACTOR shall work with providers to obtain their NPI.
- 14.2.7 The NPI for both the pay to provider as well as the rendering provider shall be reported.
- 14.2.8 The CONTRACTOR must use standardized conventions for provider names, addresses, provider type, and other provider descriptive information, as specified by the Department, in order to ensure provider data comparability across all CONTRACTORS.
- 14.2.8.1 Upon request by the Department, the CONTRACTOR shall provide additional information in order to correctly identify providers.
- 14.2.9 The Department will publish the version of the Diagnosis-Related Group (DRG) grouper that the CONTRACTOR will be required to use for submission of hospital claims data.
- 14.2.9.1 The CONTRACTOR will have up to three hundred and sixty-five (365) days from the initiation of this contract to convert its claims payment system to the Department-approved DRG grouper.

- 14.2.9.2 The CONTRACTOR shall update the DRG Grouper to the version published by the Department.
- 14.2.10 The CONTRACTOR shall comply with industry-accepted clean claim standards for all encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic claim formats to support proper adjudication of a claim.
- 14.2.10.1 All encounter data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of claims processing.
- 14.2.10.2 Any individual record submission that contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the CONTRACTOR for immediate correction.
- 14.2.10.2.1 Due to the need for timely data and to maintain integrity of processing sequence, the CONTRACTOR shall address any issues that prevent processing of an encounter in accordance with procedures specified in Managed Care Policy and Procedure Manual.
- 14.2.11 The CONTRACTOR shall be required to submit all data relevant to the adjudication and payment of claims in sufficient detail, as defined by the Department, in order to support comprehensive financial reporting and utilization analysis.
- 14.2.12 The CONTRACTOR is not responsible for submitting contested claims or encounters until final adjudication has been determined.
- 14.2.12.1 The CONTRACTOR must submit void encounters for claims that are recouped in full.

14.2.13 **Submission of Test Encounter Data**

The CONTRACTOR must successfully exchange encounter data for all applicable form types with the Department no later than ninety (90) days after the start of the contract.

14.2.13.1 **Test Requirement**

14.2.14.1.1 The CONTRACTOR shall be responsible for passing a test process for each of the HIPAA transaction types prior to submitting production encounter data.

14.2.14.1.2 The CONTRACTOR shall pass the testing phase for all encounter claim type submissions prior to the project plan implementation date.

14.2.14.1.3 The CONTRACTOR shall not be permitted to provide services under this contract, nor shall the CONTRACTOR receive capitation payment, until it has passed the testing and production submission of encounter data.

14.2.14.1.4 The details of the testing process and handling of errors are provided in the Medicaid Managed Care Systems Guide.

14.2.14.1.5 The CONTRACTOR shall submit the testing encounter data to the Department's fiscal agent electronically according to the specifications in the Medicaid Managed Care Systems Guide

14.2.13.2 Submitter Identification Number (ID)

14.2.14.2.1 The CONTRACTOR shall make application in order to obtain a Submitter Identification Number, according to the instructions listed in the CONTRACTOR ("MCO") Systems Guide.

14.2.13.3 Test File Format(s)

14.2.14.3.1 The CONTRACTOR shall utilize production encounter data, systems, tables, and programs when processing encounter test files.

14.2.14.3.2 The CONTRACTOR shall submit error-free production data once testing has been approved for all of the encounter claims types.

14.2.14 Eligibility and Enrollment Exchange Requirements

14.2.14.1 The CONTRACTOR shall systematically update its eligibility/enrollment databases within twenty-four (24) hours of receipt of said files.

14.2.14.1.1 Any outbound 834 transactions which fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt.

14.2.14.2 The CONTRACTOR shall report to the Department, in a form and format to be provided by the Department, outbound 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed.

14.2.14.3 Any transactions that are not updated/loaded within twenty-four (24) hours of receipt from the Department and/or persistent issues with high volumes of transitions that require manual upload may require the CONTRACTOR to initiate a Corrective Action Plan for resolution of the issues preventing compliance.

14.2.14.3.1 If the CONTRACTOR has reason to believe they may not meet this requirement based on unusual circumstances, the CONTRACTOR must notify the Department and the Department may make an exception without requiring a Corrective Action Plan.

- 14.2.14.4 The CONTRACTOR shall transmit to the Department, in the formats and methods specified in the HIPAA Implementation and SCDHHS Companion guides or as otherwise specified by SCDHHS: member address changes, telephone number changes, and PCP.
- 14.2.14.5 The CONTRACTOR shall be capable of uniquely identifying a distinct Medicaid member across multiple populations and Systems within its span of control.
- 14.2.14.6 The CONTRACTOR shall be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by the Department, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.
- 14.2.15 **FQHC/ RHC Encounter Reporting**
- 14.2.15.1 The CONTRACTOR shall submit a quarterly report of Encounter/claims data, organized by date of service, for all contracting FQHCs and RHCs for State Plan required reconciliation purposes.
- 14.2.15.2 See the Managed Care Policy and Procedure Manual and the Companion Guide for FQHC/RHC Encounter reporting specifications.
- 14.2.15.3 The Encounter data shall be submitted no later than sixty (60) calendar days following the quarter's end.

### **14.3 Errors and Encounter Validation**

- 14.3.1 The CONTRACTOR agrees to submit complete and accurate encounter files, containing all paid claims and all clinically denied claims to the Department.
- 14.3.1.1 The CONTRACTOR should submit encounter files daily. The Department will aggregate submitted encounters on a monthly basis. Departmental validation will occur on the monthly aggregated encounter records. Encounters files are due no later than fifteen (15) calendar days after the end of the reporting month.
- 14.3.1.2 The Department will generate a response file for all submitted encounter records on a timely basis, to allow the CONTRACTOR sufficient time to resubmit the corrected encounters.
- 14.3.1.3 The CONTRACTOR must correct and resubmit all previously denied encounter records within ninety (90) days after initial encounter reporting due date.
- 14.3.1.4 Encounter submissions must be at least one hundred percent (100%) accurate within ninety (90) calendar days after the encounter-reporting month.

- 14.3.1.5 The CONTRACTOR shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness.
- 14.3.2 If the Department, or the CONTRACTOR, determines at any time that the CONTRACTOR's Encounter Data is not complete and accurate, the CONTRACTOR shall:
- 14.3.2.1 Notify the Department prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;
  - 14.3.2.2 Submit for Department approval, within a time frame established by the Department, which shall in no event exceed thirty (30) days from the day the CONTRACTOR identifies or is notified that it is not in compliance with the Encounter Data requirements, a Corrective Action Plan (CAP) to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;
  - 14.3.2.3 Implement the Department-approved corrective action plan (CAP) within a time frame approved by the Department, which shall in no event exceed thirty (30) days from the date that the CONTRACTOR submits the corrective action plan to the Department for approval; and
  - 14.3.2.4 Participate in a validation study to be performed by the Department, and/or their designee, following the end of a twelve (12) month period after the implementation of the corrective action plan to assess whether the Encounter Data is complete and accurate.
  - 14.3.2.5 Correct the error(s) and submit accurate reports as follows:
    - 14.3.2.5.1 For Encounter submissions – in accordance with the timeframes specified in this Section of this Contract.
    - 14.3.2.5.2 For all other reports – fifteen (15) calendar days from the date of discovery by the CONTRACTOR or date of written notification by the Department (whichever is earlier).
- 14.3.3 Encounter data received from the CONTRACTOR will be enhanced and edited by standards established by the Department.
- 14.3.4 The Department will reject or report individual claims or encounters failing certain edits, as deemed appropriate and necessary by the Department to ensure accurate processing or encounter data quality, and will return these transactions to the CONTRACTOR for research and resolution.
- 14.3.4.1 A summary document will also be sent with each encounter submission that identifies the number of encounters submitted and a breakdown of any errors/issues.

14.3.4.2 This enhanced file and summary file will be provided to the CONTRACTOR within two (2) business days after the CONTRACTOR submits the encounter data to the Department in a format specified in the Report Companion Guide encounter/edit information.

14.3.4.3 An Erred Encounter Record File shall be transmitted to the CONTRACTOR electronically on 999-acknowledgement file and 277CA response file for correction and submission.

14.3.5 The Department will require expeditious action on the part of the CONTRACTOR to resolve errors or problems associated with said claims or the adjudication thereof, including any necessary changes or corrections to any systems, processes or data transmission formats, in accordance with the procedure specified in Managed Care Policy and Procedure Manual.

14.3.5.1 Generally the CONTRACTOR shall, unless otherwise directed by the Department, address one hundred percent (100%) of reported errors within ninety (90) calendar days.

14.3.5.2 Such errors will be considered acceptably addressed when the CONTRACTOR has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute.

14.3.5.2.1 The Department may require resubmission of the transaction with reference to the original in order to document resolution.

#### 14.3.6 **Data Validation**

14.3.6.1 Per CMS requirements, the Department or its agents will conduct encounter validation studies of the CONTRACTOR's encounter submissions.

14.3.6.1.1 These studies may result in sanctions of the CONTRACTOR and/or require a corrective action plan for noncompliance with related encounter submission requirements.

14.3.6.2 Data quality efforts of the Department shall incorporate the following standards for monitoring and validation:

14.3.6.2.1 Edit each data element on the Encounter Record for required presence, format, consistency, reasonableness and/or allowable values;

14.3.6.2.2 Edit for Member eligibility;

14.3.6.2.3 Perform automated audit processing (e.g. duplicate, conflict, etc.) using history Encounter Record and same-cycle Encounter Record;

14.3.6.2.4 Identify exact duplicate Encounter Record;

- 14.3.6.2.5 Maintain an audit trail of all error code occurrences linked to a specific Encounter; and
- 14.3.6.2.6 Update Encounter history files with both processed and incomplete Encounter Record.
- 14.3.6.3 The purpose of encounter validation studies is to compare recorded utilization information from a medical record or other source with the CONTRACTOR's submitted encounter data. Any and all covered services may be validated as part of these studies.
- 14.3.6.3.1 The criteria used in encounter validation studies may include timeliness, correctness and omission of encounters. Refer to the Managed Care Policy and Procedure Manual for further information.
- 14.3.6.4 The CONTRACTOR shall participate in site visits and other reviews and assessments by CMS and the Department, or its designee, for the purpose of evaluating the CONTRACTOR's collection and maintenance of Encounter Data;
- 14.3.6.5 Upon request by the Department, or their designee, the CONTRACTOR shall provide medical records of Enrollees and a report from administrative databases of the Encounters of such Enrollees in order to conduct validation assessments.
- 14.3.6.6 Such validation assessments may be conducted annually.
- 14.3.6.7 The Department may revise study methodology, timelines and sanction amounts based on agency review or as a result of consultations with CMS.
- 14.3.6.7.1 The CONTRACTOR will be notified in writing of any significant change in study methodology.
- 14.3.6.8 Additionally, upon request, the CONTRACTOR shall reconcile all encounter data submitted to the State to control totals and to the CONTRACTOR's Medical Loss Ratio (MLR) reports and supply the reconciliation to the Department with each of the Medical Loss Ratio report submissions as specified in the Managed Care Policy and Procedures Manual.
- 14.3.6.9 In order to provide an incentive for complete and accurate reporting and reconcile Encounter submissions with CONTRACTOR experience, the CONTRACTOR is required to submit quarterly Capitation Rate Calculation Sheet (CRCS) reports to the Department.
- 14.3.6.9.1 This is to be done in a timely, complete and accurate manner.

14.3.6.9.2 The data elements, and other requirements for the report format, can be found in the Medicaid Managed Care Reports Companion Guide.

14.3.6.9.3 CRCS reports are due within 105 days of the end of each calendar quarter.

#### **14.4 System and Information Security and Access Management Requirements**

14.4.1 The CONTRACTOR's Systems shall employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

14.4.1.1 Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;

14.4.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by the Department and the CONTRACTOR; and

14.4.1.3 Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

14.4.2 The CONTRACTOR shall make System information available to duly authorized representatives of the Department and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

14.4.3 The CONTRACTOR's Systems shall contain controls to maintain information integrity.

14.4.3.1 These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the CONTRACTOR and the Department.

14.4.4 Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

14.4.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

14.4.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;

- 14.4.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;
- 14.4.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs;
- 14.4.4.5 Facilitate auditing of individual records as well as batch audits;
- 14.4.4.6 Be maintained online for no less than two (2) years; additional history shall be retained for no less than ten (10) years and shall be retrievable within 48 hours.
- 14.4.5 The CONTRACTOR's Systems shall have inherent functionality that prevents the alteration of finalized records.
- 14.4.6 The CONTRACTOR shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein.
- 14.4.6.1 The CONTRACTOR shall provide the Department with access to data facilities upon request. The physical security provisions shall be in effect for the life of this Agreement.
- 14.4.7 The CONTRACTOR shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.
- 14.4.8 The CONTRACTOR shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.
- 14.4.9 The CONTRACTOR shall put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CONTRACTOR's span of control.
- 14.4.9.1 This includes but is not limited to: no provider or member service applications shall be directly accessible over the Internet and shall be appropriately isolated to ensure appropriate access.
- 14.4.10 The CONTRACTOR shall ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved in writing by the Department.
- 14.4.11 The CONTRACTOR shall comply with recognized industry standards governing security of state and federal automated data processing systems and information processing.

14.4.11.1 At a minimum, the CONTRACTOR shall conduct a security risk assessment and communicate the results in an information security plan provided prior to the start date of operations.

14.4.11.2 The risk assessment shall also be made available to appropriate federal agencies.

#### 14.4.12 **Subcontractor(s) and Encounter Data Reporting**

##### 14.4.12.1 Interfaces.

14.4.12.1.1 All encounter data shall be submitted to the Department directly by the CONTRACTOR.

14.4.12.1.2 The Department shall not accept any encounter data submissions or correspondence directly from any subcontractors, and the Department shall not forward any electronic media, reports or correspondence directly to a subcontractor.

14.4.12.1.3 The CONTRACTOR shall be required to receive all electronic files and hardcopy material from the Department, or its appointed fiscal agent, and distribute it within its organization or to its subcontractors as needed.

##### 14.4.12.2 Communication

14.4.12.2.1 The CONTRACTOR and its subcontractors shall be represented at all Department meetings scheduled to discuss any issue related to the encounter data requirements.

14.4.12.2.2 All Subcontracts with Providers or other vendors of service must have provisions requiring that Encounter Record is reported/submitted in an accurate and timely fashion.

#### 14.4.13 **Future Encounter Data Reporting Requirements**

14.4.13.1 At the present time, the Centers for Medicare and Medicaid Services (CMS) continue to add and update electronic data standards for all health care information, including encounter data.

14.4.13.2 The CONTRACTOR shall be responsible for completing and paying for any modifications required to submit encounter data electronically, according to the same specifications and timeframes outlined by CMS for the Department's MMIS.

## 15 QUALITY ASSESSMENT, MONITORING AND REPORTING

### 15.1 Quality Assessment and Performance Improvement (QAPI)

15.1.1 The CONTRACTOR shall develop Quality Assessment and Performance Improvement (QAPI) activities in accordance with this Section of this Contract. These activities shall be aimed at improving in the quality of care provided to enrolled members through established quality management and performance improvement processes.

15.1.2 The CONTRACTOR will establish and implement a system of QAPI as required by 42 CFR §§ 438.240-438.242 and detailed within the Managed Care Policy and Procedure Manual.

15.1.3 The CONTRACTOR shall have an ongoing quality assessment and performance improvement program.

15.1.4 At a minimum, the CONTRACTOR shall:

15.1.4.1 Conduct performance improvement projects.

15.1.4.1.1 These projects must be designed to achieve, through ongoing measurements and intervention, improve the overall health status of its Members.

15.1.4.1.2 This improvement should be sustained over time and have favorable effects on both health outcomes and member satisfaction

15.1.4.2 Submit performance measurement data as described in this Section of this Contract.

15.1.4.3 Have in effect mechanisms to detect both underutilization and over utilization of services

15.1.4.4 Have in effect mechanisms to assess the Quality and appropriateness of care furnished to Medicaid Managed Care Members with special healthcare needs

**15.1.5 The Quality Assessment (QA) Program Standards:**

15.1.5.1 The Quality Assessment Program (QAP) is required to meet the following minimum standards:

15.1.5.1.1 Is consistent with applicable federal regulations

15.1.5.1.2 Provides for review by appropriate health professionals of the process followed in providing health services

15.1.5.1.3 Provides for systematic data collection of performance and patient results

15.1.5.1.4 Provides for interpretation of this data to the practitioners

**15.1.6 Quality Assurance Committee**

15.1.6.1 The CONTRACTOR's Quality Assessment (QA) program shall be directed by a QA committee which has the substantial involvement of the medical director and includes membership from:

15.1.6.1.1 A variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.)

15.1.6.1.2 Participating network Providers from a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.) with emphasis on primary care—including obstetric and pediatric representation

15.1.6.1.3 Representation from the CONTRACTOR's management or Board of Directors

15.1.6.2 The QA Committee shall be located within the CONTRACTOR such that it can be responsible for all aspects of the QA program.

15.1.6.3 The QA Committee shall meet at minimum quarterly.

15.1.6.4 The QA Committee shall produce dated and signed written documentation of all meetings and committee activities. The CONTRACTOR shall make these documents available to the Department upon request.

15.1.6.5 The QA activities of CONTRACTOR's Providers and subcontractors shall be integrated into the overall CONTRACTOR QA program.

15.1.6.5.1 The CONTRACTOR's QA program shall provide feedback to the Providers and Subcontractors regarding the integration of, operation of, and corrective actions necessary in Provider/Subcontractor QA efforts.

15.1.6.6 The CONTRACTOR shall have written procedures that address the CONTRACTOR's approach to measurement, analysis, and interventions for QA activity findings.

15.1.6.6.1 This procedure should include monitoring activities following intervention implementation.

15.1.6.7 The measurement, analysis and interventions shall be documented in writing and submitted to the CONTRACTOR's Board of Directors and be made available to the Department upon request.

## **15.2 Performance Improvement Projects (PIP)**

15.2.1 The CONTRACTOR is required to conduct Performance Improvement Projects (PIP) as directed by the Department. Such topics may be specified in consultation with CMS and other stakeholders.

- 15.2.1.1 The CONTRACTOR shall ensure that it conducts performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.
- 15.2.1.2 The CONTRACTOR shall implement the PIP in accordance with Managed Care Policy and Procedure Manual guidelines.
- 15.2.2 The CONTRACTOR shall have an ongoing program of performance improvement projects (a minimum of two (2) projects) that focus on clinical and non-clinical areas. In accordance with 42 CFR 438.240 the PIP must involve the following:
- 15.2.2.1 Measurement of performance using objective quality indicators.
  - 15.2.2.2 Implementation of system interventions to achieve improvement in quality.
  - 15.2.2.3 Evaluation of the effectiveness of the interventions.
  - 15.2.2.4 Planning and initiation of activities for increasing or sustaining improvement
- 15.2.3 Each PIP must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregated to produce new information on Quality of care each year [42 CFR § 438.240 (d) (2)].

### **15.3 Member Satisfaction Survey**

- 15.3.1 The CONTRACTOR shall monitor Member perceptions of accessibility and adequacy of services provided by the CONTRACTOR.
- 15.3.2 The CONTRACTOR shall use the NCQA Health Plan Consumer Assessment of Healthcare Providers and Systems (CAHPS) as its primary survey for the determination of Member satisfaction.
- 15.3.3 The CONTRACTOR may employ additional tools to supplement the Member satisfaction information gathered from the CAHPS survey. These tools may include the use of additional Member surveys, anecdotal information gathered from Member or Provider interactions, grievance and appeals data, and Enrollment and Disenrollment information.
- 15.3.4 The CONTRACTOR shall submit its CAHPS results to the Department, or its designee, by June 15<sup>th</sup> of each year. This information shall be provided in an editable format that allows for aggregation and analysis of the raw data by the Department.
- 15.3.5 The CONTRACTOR shall report the results of any additional Member satisfaction measurement or improvement efforts to the Department annually.

15.3.6 The CONTRACTOR shall develop a corrective action plan when Members report statistically significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported.

#### **15.4 Quality Performance Measures**

15.4.1 Each CONTRACTOR must require that its external quality review organization, on an annual basis:

15.4.1.1 Measure and report to the Department its performance, using standard measures required by the Department;

15.4.1.2 Submit to the Department data that enables the Department to measure the CONTRACTOR's performance.

15.4.2 Measures will include, but may not be limited to, all Medicaid plan measures required by the NCQA for accreditation, in addition to any additional measures specified in the Managed Care Policy and Procedure Manual.

15.4.3 After completion of the CONTRACTOR's annual HEDIS data collection, reporting and performance measure audit, the CONTRACTOR shall submit to the Department the Final Auditor's Report issued by the NCQA certified audit organization in an electronic format by no later than June 15<sup>th</sup>.

15.4.4 In addition, for each measure being reported, the CONTRACTOR may provide supplemental information indicating the trending of the results from previous years.

15.4.5 Where applicable, benchmark data and performance goals established for the reporting year shall be indicated.

15.4.6 The CONTRACTOR shall include the values for the denominator and numerator used to calculate the measures.

15.4.7 HEDIS measures must be submitted in accordance with the NCQA-specified standards and auditing and submission process.

15.4.8 The Centers for Medicare and Medicaid Services (CMS) has been working in partnership with states in developing core performance measures for Medicaid and CHIP programs. The CONTRACTOR must comply with national performance measures and levels that may be identified and developed by CMS. The Department shall communicate these requirements via bulletin when they become available and shall update the Managed Care Policy and Procedure Manual.

15.4.9 The CONTRACTOR must have in place a process for internal monitoring of Performance Measure rates, using a standard methodology established or adopted by Department, for each required Performance Measure.

- 15.4.10 The CONTRACTOR's Quality Assessment/Performance Improvement Program will report its performance on an ongoing basis to its Administration, as defined by the CONTRACTOR's internal quality improvement policies and procedures.
- 15.4.11 All Performance Measures apply to all full-benefit member populations [42 CFR 438.240(a)(2), (b)(2) and (c)].
- 15.4.12 The Department may analyze and report results by line of business, by region or county, and/or applicable demographic factors.

### **15.5 CONTRACTOR Quality Withhold and Bonus Program**

15.5.1 The Department has established a quality Withhold and Bonus Program whereby the CONTRACTOR is at-risk for performances based on quality objectives for a calendar year and is eligible to receive additional funds for meeting targets specified in the contract and the Managed Care Policy and Procedure Manual.

#### **15.5.2 Withhold Program**

15.5.2.1 The Department shall withhold some percentage of the CONTRACTOR's total capitation payment, as outlined in Appendix B and Managed Care Policy and Procedure Manual.

15.5.2.2 Beginning with calendar year 2015, withhold dollars shall be returned to the CONTRACTOR if following requirements are met:

15.5.2.2.1 The Department shall continue to operate the Withhold and Bonus Program outlined in the 2012 Managed Care Contract, Appendix B, and corresponding Managed Care Policy and Procedure Manual for withhold (calendar) year 2014.

15.5.2.2.2 The CONTRACTOR must meet the Value-Oriented Contract (VOC) target, as described in Section 15 of this Contract. Failure to meet the VOC target shall result in disqualification to receive any of the withhold dollars.

15.5.2.2.3 The CONTRACTOR must meet Minimum Performance Standards (MPS), as described in Section 15 of this Contract.

#### **15.5.3 Bonus Pool**

15.5.3.1 A Bonus Pool is a payment that involves undistributed funds accumulated from Withhold amounts forfeited by the CONTRACTORS. These funds are used to create a bonus pool.

15.5.3.2 Bonuses will be paid to CONTRACTORS for achieving at or above the 75th percentile in a withhold measure, in a manner determined by the Department.

- 15.5.3.3 The Department shall distribute bonus pool funds based on the relative performance of the CONTRACTOR on the Withhold metrics, or some subset thereof as defined in the Managed Care Policy and Procedure Manual.
- 15.5.4 During the first two (2) years of operation in the South Carolina Medicaid market, a modified Bonus and Withhold Program shall govern a new CONTRACTOR, as defined in the Managed Care Policy and Procedure Manual. This modified program applies to new CONTRACTORS only.
- 15.5.5 In the event that this Contract is terminated, the CONTRACTOR shall forfeit any and all withhold funds for the calendar year in which the termination occurs. Additionally, upon termination of this Contract, the CONTRACTOR will refund to the Department any and all incentive money paid to the CONTRACTOR, excluding any provider-designated incentives, for the calendar year of the termination. The refund may exclude provider-designated incentive paid and distributed upon authorization by the Department. The CONTRACTOR shall be solely responsible for the refund and shall not seek or attempt to collect any part of the incentive from any Provider(s) to whom CONTRACTOR had previously paid a portion of the incentive.

#### **15.6 Minimum Performance for Withhold Measures**

- 15.5.1 The Department shall publish and maintain a specific list of quality metrics, the Withhold Metrics, for which the CONTRACTOR is expected to meet a minimum level of performance as identified in the Managed Care Policy and Procedure Manual. These minimum levels of performance shall be herein referred to as Minimum Performance Standards (MPS).
- 15.5.2 Details regarding the baseline for the MPS and methodology for calculating whether a measure has been met will be detailed in the Managed Care Policy and Procedure Manual. Whenever possible, the Department will adopt the standard HEDIS methodology for the purposes of evaluating the Withhold Measures.
- 15.5.3 If a CONTRACTOR does not achieve the HEDIS National Medicaid 25<sup>th</sup> percentile for any of the Withhold Measures, the CONTRACTOR will be required to submit a corrective action plan (CAP) and be subject to a liquidated damage of \$250,000 dollars for each Withhold Measure that fails to meet National Medicaid HEDIS 25<sup>th</sup> percentile. The liquidated damage shall not apply during the benchmark year or during the transition year for measures that were below the 25<sup>th</sup> percentile during the benchmark year, as defined in the Managed Care Policy and Procedure Manual.
- 15.5.4 The Department may require the CONTRACTOR to demonstrate that they are allocating increased administrative resources to improving rates for a particular measure.

15.5.5 In the event the CONTRACTOR is required to submit a CAP, the plan must be submitted to the Department within thirty (30) days of receipt of notification of the deficiency from the Department or its designee.

15.5.5.1 The Department will approve the plan before the CONTRACTORS implements the CAP.

15.6.1.1 The Department or the Department's designee may conduct desktop or on-site reviews to verify compliance with a corrective action plan as needed.

### **15.7 Value Oriented Contracting (VOC)**

15.7.1 To improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes, the Department expects the CONTRACTOR will support principles of Catalyst for Payment Reform (CPR) and participate in multi-payer health care payment innovation activities as outlined below.

15.7.2 The CONTRACTOR shall design and implement payment methodologies with its network providers that are designed to cut waste and/or reflect value.

15.7.2.1 Payments that cut waste are those that, by their design, reduce unnecessary payment and unnecessary care (e.g. elective cesarean deliveries).

15.7.2.2 Payments that reflect value are those that are tied to provider performance and may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.

15.7.2.3 Payment strategies will include but not be limited to the following:

15.7.2.3.1 Pay providers differentially according to performance (and reinforce with benefit design).

15.7.2.3.2 Design approaches to payment that cut waste while not diminishing quality, including reducing unwarranted payment variation.

15.7.2.3.3 Design payments to encourage adherence to clinical guidelines.

15.7.2.3.4 Develop payment strategies to reduce unwarranted price variation, such as reference or value pricing (e.g. analysis of price variation among network providers by procedure and service types, pilot value pricing programs, encouragement of member value-based pricing information, and center of excellence pricing)

15.7.2.3.5 Rebalance payment between primary and specialty care in which the CONTRACTOR will implement delivery system pilot programs such as medical home and telemedicine.

15.7.2.3.6 Examples of payment methodologies that are consider value-oriented are those structured to reduce unnecessary care for services and include but are not limited to fee-for-service based shared savings on quality; non-fee-for-service (non-FFS) based with quality such as bundled payments, partial capitation, fully capitated payments, global rates; shared risk programs, and high-performance-based contracts.

15.7.2.4 Sub-capitated or bundled payment arrangements that are not value-oriented are not considered value-oriented payment to meet the target for a measurement year.

15.7.2.5 The CONTRACTOR has discretion in designing value-oriented payment to meet the requirements of this Section of this Contract.

15.7.2.6 However, to the extent that the Department has established clinical outcomes objectives that can be supported by value-oriented contracting, the CONTRACTOR shall implement payment reform strategies to support the Department's initiatives as outlined in the Managed Care Policy and Procedure Manuals.

15.7.2.6.1 Such initiatives may include but are not limited to maternity payment policies to discourage elective deliveries prior to thirty-nine (39) weeks and reduction of hospital readmissions, etc.

15.7.2.7 The Department reserves the right to approve/disapprove all payment reform initiatives submitted by the CONTRACTOR, as stipulated in the Managed Care Policy Manual.

**15.7.3 CONTRACTOR Targets for Value-Oriented Contracting**

15.7.3.1 The CONTRACTOR shall implement value-oriented purchasing and reach the following targets for each measurement year as outlined in Table 15.1.

**Table 15.1** CONTRACTOR Targets for Value-Oriented Contracting by State Calendar Year, 2015 to 2017

Year	Target
Year 1 (January 1, 2015 through December 31, 2015)	5% of total payment
Year 2 (January 1, 2016 through December 31, 2016)	12% of total payment
Year 3 (January 1, 2017 through December 31, 2017)	20% of total payment

**15.7.4 CONTRACTOR Reporting and Value-Oriented Contracting**

15.7.4.1 The methodology for evaluating the VOC percentage and the reporting requirements related to the VOC requirement shall be detailed in the Managed Care Policy Manual.

15.7.4.2 Failure to meet the minimum target for each measurement year will result in the CONTRACTOR becoming ineligible to participate in the return of the withhold payments in Section 15 of this Contract.

### **15.8 NCQA Accreditation**

15.8.1 The CONTRACTOR must achieve ‘Commendable’ status from NCQA within three years of the effective date of this contract or within four years of entering the South Carolina Medicaid market, whichever comes first.

15.8.2 The Department will not recognize accreditation under the New Health Plan Program in meeting this requirement.

15.8.3 Once the CONTRACTOR achieves “Commendable” status, the CONTRACTOR must maintain the accreditation through the term of the Contract.

15.8.4 If one of the anniversary requirement dates described in Section 15 of this Contract falls during a HEDIS evaluation period, the results at the conclusion of that evaluation shall be used in assessing the CONTRACTOR’s status.

15.8.5 If the CONTRACTOR fails to achieve the NCQA accreditation level described in Section 15 of this Contract, the CONTRACTOR must submit a corrective action plan (CAP). Failure to achieve the required level of accreditation during the subsequent review may be cause for termination.

15.8.5.1 If the CONTRACTOR fails to achieve the required accreditation status, the subsequent review must be completed no less than 12 months after the initial decision.

15.8.5.2 During the period between the CONTRACTOR’s failure to achieve the required level of accreditation and the subsequent review, the Department, at its discretion, may impose liquidated damages, cease the enrollment of additional Members to the CONTRACTOR’s Health Plan, and reassign Members who are currently enrolled in the CONTRACTOR’s Health Plan.

### **15.9 External Quality Review (EQR)**

15.9.1 The CONTRACTOR shall participate and cooperate in an annual External Quality Review in accordance with 42 CFR § 438.204.

15.9.2 The review will include, but not be limited to, review of quality outcomes, timeliness of, and access to, the services covered under the contract.

15.9.3 The CONTRACTOR shall provide information required to complete the review as requested by the Department or its designee, including but not limited to Quality Assessment Committee meeting minutes and annual medical audits to ensure that it provides quality and accessible health care to Medicaid Managed Care Members, in accordance with standards contained in the Managed Care Policy and Procedure Manual.

- 15.9.4 Such audits shall allow the Department or its representative to review individual medical records and identify and collect management data, including, but not limited to, survey and other information concerning the use of services and the reasons for disenrollment.
- 15.9.5 The standards by which the CONTRACTOR will be surveyed and evaluated will be at the Department's sole discretion and approval.
- 15.9.5.1 If deficiencies are identified, the CONTRACTOR must submit a Corrective Action Plan (CAP) for approval addressing how the CONTRACTOR will remediate any deficiencies and the timeframe in which such deficiencies will be corrected.
- 15.9.6 The CONTRACTOR must receive prior approval from the Department for the CAP.
- 15.9.7 The CONTRACTOR will provide a quarterly update to the Department regarding its progress in correcting the deficiencies. See the Managed Care Policy and Procedure Manual.

#### **15.10 Provider Preventable Conditions**

- 15.10.1 The CONTRACTOR shall implement a no payment policy and a quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions and according to federal regulations at 42 CFR §§ 434, 438, and 447.
- 15.10.2 Policies and procedures shall be submitted to the Department for review and approval prior to implementation of the CONTRACTOR's program.
- 15.10.3 Updates to the program shall be made as the CMS and the Medicaid FFS program changes.
- 15.10.3.1 Updates generated by CMS are effective the date of the announcement.
- 15.10.4 The CONTRACTOR shall identify Hospital-Acquired Conditions for non-payment as identified by Medicare and as detailed in the Managed Care Policy and Procedure Manual.
- 15.10.5 The CONTRACTOR shall identify Other Provider-Preventable Conditions for non-payment, as detailed in the Managed Care Policy and Procedure Manual.

## **16 DEPARTMENT'S RESPONSIBILITIES**

### **16.1 Department Contract Management**

16.1.1 The Department will be responsible for the administrative oversight of the Medicaid Managed Care Program. As necessary and appropriate, the Department will provide clarification of the Medicaid Managed Care Program and Medicaid policy, regulations and procedures. The Department will be responsible for the management of this Contract. All Medicaid policy decision making or interpretations of this Contract will be made solely by the Department and are considered final. The management of this Contract will be conducted in the best interests of the Department and the Medicaid Managed Care Members.

16.1.2 Whenever the Department is required by the terms of this Contract to provide written notice to the CONTRACTOR, the Director of the Department or the designee will sign such notice.

### **16.2 Payment of Capitated Rate**

16.2.1 The CONTRACTOR shall be paid a Capitated Payment in accordance with the capitated rates specified in Appendix B, Capitation Rate(s) and Rate Methodology. These rates will be reviewed and adjusted at the Department's discretion. These rates shall not exceed the limits set forth in 42 CFR § 438.6(c)(2013).

### **16.3 Notification of Medicaid Managed Care Program Policies and Procedures**

16.3.1 The Department will provide the CONTRACTOR with updates to appendices, information on and interpretation of all pertinent federal and state Medicaid regulations, and Medicaid Managed Care Program policies, procedures and guidelines affecting the provision of services under this Contract. The CONTRACTOR will submit written requests to the Department for additional clarification, interpretation or other information in a grid format specified by the Department in the Medicaid Managed Care Policy and Procedure Manual. The Department's provision of such information does not relieve the CONTRACTOR of its obligation to keep informed of applicable federal and state laws related to its obligations under this Contract.

### **16.4 Quality Assessment and Monitoring Activities**

16.4.1 The Department is responsible for monitoring the CONTRACTOR's performance to assure the CONTRACTOR is in compliance with this Contract provisions and the Medicaid Managed Care Policy and Procedure Manuals. The Department, or its designee, shall coordinate with the CONTRACTOR to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.

16.4.2 On at least an annual basis, the Department, or its designee, shall inspect the CONTRACTOR's facilities, as well as auditing and/or review of all records developed under this Contract including periodic medical audits, Grievances, enrollments, disenrollments, termination, utilization and all financial records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.

16.4.3 The CONTRACTOR shall have the right to review any of the findings and recommendations resulting from such contract monitoring and audits. However, once the Department finalizes the results of monitoring and/or auditing, the CONTRACTOR must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in liquidated damages, sanctions, enrollment restriction, marketing restrictions, change in the assignment algorithm, or termination of this Contract.

### **16.5 Fee-for-Service (FFS) Reporting to MCOs**

16.5.1 To facilitate the treatment of Medicaid Managed Care Members the Department will be responsible for providing the CONTRACTOR with a recent retrospective fee-for-service history on all of the CONTRACTOR's then current Medicaid Managed Care Members, if available. This history will contain a maximum of twenty-four (24) months from the month the Medicaid Managed Care Member was determined to be an Eligible.

### **16.6 Request for Plan of Correction**

16.6.1 The Department will monitor the CONTRACTOR's quality of care outcome activities and corrective actions taken as specified in the Medicaid Managed Care Program Quality Assessment Plan in the Medicaid Managed Care Policy Manual.

16.6.2 The CONTRACTOR must make provisions for prompt response to any detected deficiencies or contract violations and for the development of corrective action initiatives relating to this Contract.

### **16.7 External Quality Review**

16.7.1 The Department will perform periodic medical audits to determine whether the CONTRACTOR furnished quality and accessible health care to Medicaid Managed Care Members in compliance with 42 CFR § 438.358 (2010, as amended). The Department may contract with an External Quality Review Organization (EQRO) to perform the periodic medical audits and external independent reviews. The Medicaid Managed Care Policy and Procedure Manual list the Department's external quality assessment evaluation requirements.

### **16.8 Marketing**

16.8.1 The Department, and/or its designee shall have the right to approve, disapprove or require modification of all marketing plans, materials, activities, and member handbooks, provider manuals. This includes but is not limited to social network sites, electronic media (television, radio, internet, smart phones), advertisements whether print or electronic developed by the CONTRACTOR pursuant to this Contract. See Section 12 of this Contract and the Medicaid Managed Care Policy and Procedure Manual for guidance.

### **16.9 Grievances/Appeals**

16.9.1 The Department shall have the right to approve, disapprove or require modification of all Grievance procedures submitted under this Contract. The Department requires the CONTRACTOR to meet and/or exceed the Medicaid Managed Care Program Grievance standards as outlined in Section 9 of this Contract.

### **16.10 Training**

16.10.1 The Department will conduct Provider training and workshops on its program policies and procedures annually or more frequently if the Department deems appropriate.

## **17 TERMINATION AND AMENDMENTS**

### **17.1 Termination**

17.1.1 This Contract shall be subject to the termination provisions as provided herein. In the event of such termination, it is agreed that neither party shall be relieved from any financial obligations each may owe to the other. Medicaid Managed Care Members shall be allowed to disenroll without cause in accordance with the Department's time frame for termination. Regardless from the reason for termination, both parties understand the contract will terminate on the last day of the month of termination.

### **17.2 Termination under Mutual Agreement**

17.2.1 Under mutual agreement, the Department and the CONTRACTOR may terminate this Contract for any reason in the best interest of the Department and the CONTRACTOR. Both parties will sign a notice of termination that shall include, the anticipated date of termination, conditions of termination, and extent to which performance of work under this Contract is terminated. The CONTRACTOR will assume all incremental cost or charges associated with the termination.

### **17.3 Termination by Department for Breach**

- 17.3.1 In the event that the Department determines that the CONTRACTOR, or any of the CONTRACTOR's subcontractors, fails to perform its contracted duties and responsibilities in a timely and proper manner, or if the CONTRACTOR shall violate any of the terms of this Contract, the Department may terminate this Contract.
- 17.3.2 Notice of termination for breach will specify the manner in which the CONTRACTOR or its Subcontractor(s) has failed to perform its contractual responsibilities.
- 17.3.3 If the Department determines that the CONTRACTOR and/or its Subcontractor(s) have satisfactorily implemented corrective action within the thirty (30) calendar day notice period, the notice of termination may be withdrawn at the discretion of the Department.
- 17.3.4 The Department may withhold any monies due the CONTRACTOR pending final resolution of termination of the contract.
- 17.3.5 If damages to the Department exceed monies due to the CONTRACTOR, collection can be made from the CONTRACTOR's Fidelity Bond, Errors and Omissions Insurance, or any insurance policy or policies required under this Contract or CONTRACTOR may pay any sums directly without a bond or insurance claim.
- 17.3.6 The rights and remedies of the Department provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

#### **17.4 Termination for Unavailability of Funds**

- 17.4.1 In the event that federal and/or state funds to finance this Contract become unavailable after the effective date of this Contract, or prior to the anticipated expiration date of this Contract, the Department may terminate this Contract without penalty.
- 17.4.2 The Department shall notify the CONTRACTOR in writing of a termination for unavailability of funds.
- 17.4.3 Availability of funds shall be determined solely by the Department.

#### **17.5 Termination for CONTRACTOR Insolvency, Bankruptcy, Instability of Funds**

- 17.5.1 The CONTRACTOR's insolvency or the filing of a petition in bankruptcy by or against the CONTRACTOR shall constitute grounds for termination of this Contract for cause.
- 17.5.2 If SCDOI and/or the Department determine the CONTRACTOR has become financially unstable and/or the CONTRACTOR's license is revoked, the Department will terminate this Contract.

## **17.6 Termination by the CONTRACTOR**

- 17.6.1 The CONTRACTOR shall give the Department written notice of Intent to Terminate this Contract one hundred twenty (120) calendar days prior to the CONTRACTOR's intended last date of operation.
- 17.6.2 The CONTRACTOR shall comply with all terms and conditions stipulated in this Contract during the termination period.
- 17.6.3 In the event of a Termination by the CONTRACTOR, the CONTRACTOR will pay any costs or charges incurred by the Department, its enrollment broker, or Providers as a result of such a termination.

## **17.7 Termination for Loss of Licensure or Certification**

- 17.7.1 In the event that the CONTRACTOR loses its license issued by South Carolina Department of Insurance (SCDOI) or the appropriate licensing agency to operate or practice in South Carolina, the Department shall terminate this Contract.
- 17.7.2 Further, should the CONTRACTOR lose its certification to participate in the Title XVIII and/or Title XIX program, the Department shall terminate this Contract.
- 17.7.3 The CONTRACTOR shall pay any costs or charges incurred by the Department, its enrollment broker, or Providers as a result of a termination due to the loss of licensure or certification.

## **17.8 Termination for Noncompliance with the Drug Free Workplace Act**

- 17.8.1 In accordance with S.C. Code Ann § 44-107-60 (Supp. 2000, as amended), this Contract is subject to termination, suspension of payment, or both if the CONTRACTOR fails to comply with the terms of the Drug Free Workplace Act.
- 17.8.2 The CONTRACTOR shall pay any costs or charges incurred by the Department, its enrollment broker, or Providers as a result of such a termination.

## **17.9 Termination for Actions of Owners/Managers**

- 17.9.1 This CONTRACT is subject to termination, unless the CONTRACTOR can demonstrate changes of ownership or control, when a person with a direct or indirect ownership interest in the CONTRACTOR:
- 17.9.1.1 Has been convicted of a criminal offense under §§1128(a), 1128(b)(1), or 1128(b)(3) of the Social Security Act, in accordance with 42 CFR §1002.203;

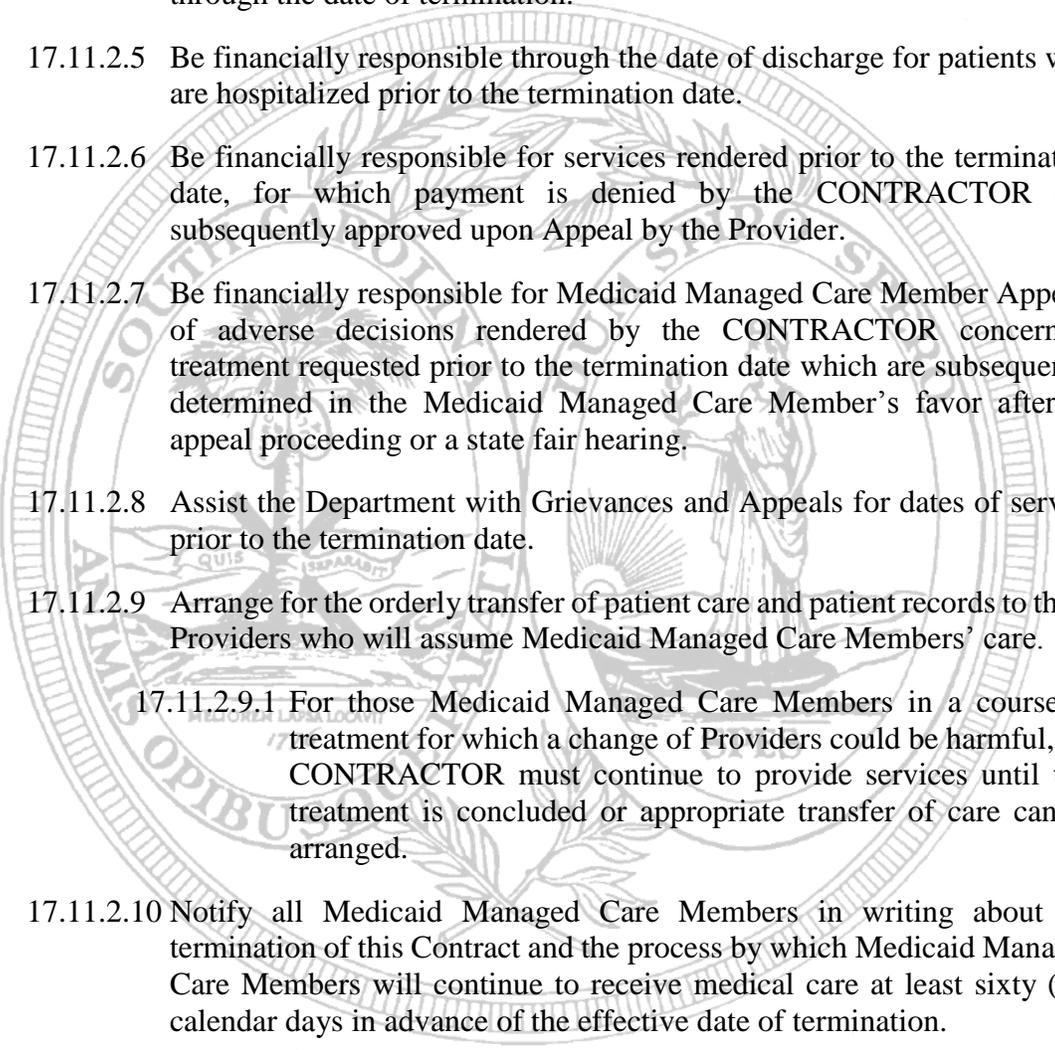
- 17.9.1.2 Has had civil monetary penalties or assessments imposed under § 1128A of the Act; or
- 17.9.1.3 Has been excluded from participation in Medicare or any state health care program; and
- 17.9.1.4 Has a direct or indirect ownership interest or any combination thereof of 5% or more, is an officer if the CONTRACTOR is organized as a corporation or a partner, if it is organized as a partnership, or is an agent or a managing employee.
- 17.9.1.5 The CONTRACTOR has a direct or indirect substantial contractual relationship with an excluded individual or entity. “Substantial Contractual Relationship” is defined as any direct or indirect business transactions that amounts to more than \$25,000 or 5% of the CONTRACTOR’s total operating expenses in a single fiscal year, whichever is less.

#### **17.10 Non-Renewal**

- 17.10.1 This Contract shall be renewed only upon mutual consent of the parties. Either party may decline to renew the Contract for any reason. However, should either party fail to provide notice of non-renewal to the other party within ninety (90) calendar days of the end date of this Contract, this Contract may be extended at the discretion of the Department for the purpose of reassigning Medicaid Managed Care Members enrolled in the CONTRACTOR’s plan and terminating the CONTRACTOR as a MCO.

#### **17.11 Termination Process**

- 17.11.1 Upon receipt of a Notice of Termination by the CONTRACTOR, the issuance of a Notice of Termination by the Department, or the entry of both parties into a Notice of Termination by Mutual Agreement, the Department shall develop a project plan that outlines the steps that must be taken by the parties to effectuate the termination of the CONTRACTOR as a Medicaid Managed Care Organization and the reassignment of Medicaid Managed Care Members to other CONTRACTOR’s Health Plans. This project plan must include anticipated dates for the completion of necessary tasks; must include the anticipated date that the termination will be effective; and must be provided to the CONTRACTOR as soon as is practicable, not to exceed five (5) business days from the date of the Notice of Termination.
- 17.11.2 Subject to the provisions stated herein, after the Notice of Termination has been submitted (whether related to one part of the CONTRACTOR’s Service Area of this entire Contract), the CONTRACTOR shall:
- 17.11.2.1 Continue to provide services under the Contract, until the effective date of the termination;

- 
- 17.11.2.2 Immediately terminate all marketing procedures and Subcontracts related to marketing;
- 17.11.2.3 Maintain claims processing functions as necessary for a minimum of twelve (12) months after the date of termination (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims.
- 17.11.2.4 Remain liable and retain responsibility for all claims with dates of service through the date of termination.
- 17.11.2.5 Be financially responsible through the date of discharge for patients who are hospitalized prior to the termination date.
- 17.11.2.6 Be financially responsible for services rendered prior to the termination date, for which payment is denied by the CONTRACTOR and subsequently approved upon Appeal by the Provider.
- 17.11.2.7 Be financially responsible for Medicaid Managed Care Member Appeals of adverse decisions rendered by the CONTRACTOR concerning treatment requested prior to the termination date which are subsequently determined in the Medicaid Managed Care Member's favor after an appeal proceeding or a state fair hearing.
- 17.11.2.8 Assist the Department with Grievances and Appeals for dates of service prior to the termination date.
- 17.11.2.9 Arrange for the orderly transfer of patient care and patient records to those Providers who will assume Medicaid Managed Care Members' care.
- 17.11.2.9.1 For those Medicaid Managed Care Members in a course of treatment for which a change of Providers could be harmful, the CONTRACTOR must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged.
- 17.11.2.10 Notify all Medicaid Managed Care Members in writing about the termination of this Contract and the process by which Medicaid Managed Care Members will continue to receive medical care at least sixty (60) calendar days in advance of the effective date of termination.
- 17.11.2.10.1 The CONTRACTOR will be responsible for all charges or costs associated with Medicaid Managed Care Member notification.
- 17.11.2.10.2 The Department must approve all Medicaid Managed Care Member notification materials prior to distribution.

- 17.11.2.10.3 Such notice must include a description of alternatives available for obtaining services after termination of this Contract.
- 17.11.2.11 Terminate all subcontracts with all health care providers to correspond with the termination of this Contract at least sixty (60) calendar days in advance of the effective date of termination.
- 17.11.2.11.1 The CONTRACTOR will be responsible for all expenses associated with Provider notification. The Department must approve all Provider notification materials prior to distribution.
- 17.11.2.12 Take all actions necessary to ensure the efficient and orderly transition of Medicaid Managed Care Members from coverage under this Contract to coverage under any new arrangement authorized by the Department, including any actions required by the Department to complete the transition of members and the termination of CONTRACTOR as a MCO.
- 17.11.2.12.1 Such actions to be taken by the CONTRACTOR shall include, but are not limited to, the forwarding of all medical or financial records related to the CONTRACTOR's activities undertaken pursuant to this Contract; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized, and pregnant Medicaid Managed Care Members in their last four (4) weeks of pregnancy.
- 17.11.2.13 The transitioning of records, whether medical or financial, related to the CONTRACTOR's activities undertaken pursuant to this Contract shall be in a form usable by the Department or any party acting on behalf of the Department and shall be provided at no expense to the Department or another CONTRACTOR acting on behalf of Department.
- 17.11.2.14 Ensure fulfillment of its obligations before and after termination, maintain the financial requirements, fidelity bonds and insurance set forth in this Contract until the Department provides the CONTRACTOR written notice that all obligations of this Contract have been met.
- 17.11.2.15 Submit reports to the Department every fourteen (14) calendar days detailing the CONTRACTOR's progress in completing its obligations under this Contract after the termination date.
- 17.11.2.15.1 The CONTRACTOR, upon completion of these obligations, shall submit a final report to the Department describing how the CONTRACTOR has completed its obligations.

- 17.11.2.15.2 The Department shall, within twenty (20) calendar days of receipt of this final report, advise in writing whether it agrees that the CONTRACTOR has met its obligations.
- 17.11.2.15.3 If the Department does not agree, then the CONTRACTOR shall complete the necessary tasks and submit a revised final report.
- 17.11.2.15.4 This process shall continue until the Department approves the final report.
- 17.11.2.16 Be responsible for all financial costs associated with its termination, including, but not limited to costs associated with changes to the enrollment broker's website, computer system, mailings, the Department and telephonic communications by the enrollment broker to the CONTRACTOR's Medicaid Managed Care Members regarding their choice period after the termination effective date and changes to any of the above-listed areas regarding information provided to all Medicaid Managed Care Members.
- 17.11.2.17 If applicable, assign to the Department in the manner and extent directed by the Department all the rights, title and interest of the CONTRACTOR for the performance of the subcontracts as needed.
- 17.11.2.17.1 In this case the Department shall have the right, in its discretion, to resolve or pay any of the claims arising out of the termination of such subcontracts.
- 17.11.2.17.2 The CONTRACTOR shall supply all information necessary for the reimbursement of any outstanding Medicaid claims.
- 17.11.2.18 Take such action as may be necessary, or as the Department may direct, for the protection of property related to this Contract that is in possession of the CONTRACTOR in which the Department has or may acquire an interest.
- 17.11.2.19 In the event the Contract is terminated by the Department, continue to serve or arrange for provision of services to the Medicaid Managed Care Members of the CONTRACTOR until the effective date of termination.
- 17.11.2.19.1 During this transition period, the Department shall continue to pay the applicable Capitation Payment.
- 17.11.2.19.2 Medicaid Managed Care Members shall be given written notice of the State's intent to terminate this Contract and shall be allowed to disenroll immediately without cause

- 17.11.2.20 Promptly supply all information necessary to the Department or its designee for reimbursement of any outstanding claims at the time of termination.
- 17.11.2.21 Any payments due under the terms of this Contract may be withheld until the Department receives from the CONTRACTOR all written and properly executed documents and the CONTRACTOR complies with all requests of the Department related to this Contract.

### **17.12 Amendments and Rate Adjustments**

17.12.1 This Contract may be amended at any time as provided in this Section of this Contract.

#### **17.12.2 Amendment due to Change in Law, Regulation, or Policy**

- 17.12.2.1 Any provision of this Contract that conflicts with federal statutes, regulations, an applicable waiver, state plan amendment, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policies.
- 17.12.2.2 Such amendment of the Contract will be effective on the effective date of the statute, regulation, or policy statement necessitating amendment, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.
- 17.12.2.3 The Department shall notify CONTRACTOR regarding such changes and this Contract shall be automatically amended to conform to such changes without necessity for executing written amendments.

#### **17.12.3 Amendment by Mutual Agreement**

- 17.12.3.1 This Contract may be amended upon mutual agreement of the parties. Such amendment must be reduced to writing and signed by the CONTRACTOR and The Department, and incorporated as a written amendment to this Contract prior to the effective date of such modification or change. Any amendment to this Contract shall require prior approval by the CMS Regional Office prior to its implementation.

#### **17.12.4 Rate Adjustments**

- 17.12.4.1 The CONTRACTOR and Department both agree that the capitation rates identified in Appendix B of this Contract shall remain in effect during the period identified in the Capitation and Reimbursement Methodology. Rates may be adjusted during the contract period based on Department and actuarial analysis, and subject to CMS review and approval.

17.12.4.2 The CONTRACTOR and Department both agree the adjustments to the capitation rate(s) required pursuant to this Section of this Contract shall occur only by written amendment to this Contract. The CONTRACTOR will have seven (7) calendar days to execute the rate amendment. Should the CONTRACTOR fail to do so the Department may at its discretion impose fine equal to \$1,500 per day and may also terminate the contract.

## **18 AUDITS, FINES AND LIQUIDATED DAMAGES**

### **18.1 Audit**

18.1.1 The CONTRACTOR will be required to undergo a performance audit conducted by the Department or its designee at least once every three years in order to determine the following:

18.1.1.1 Compliance with this contract

18.1.1.2 The effectiveness of the CONTRACTOR's program integrity and special investigation unit (SIU) activities

18.1.1.3 Compliance with all applicable federal requirements for program integrity

18.1.1.4 Accuracy and reliability of encounter data and any other information required to be reported by the CONTRACTORS

18.1.1.5 Compliance with TPL rules

18.1.1.6 Compliance with Department payment rules

18.1.1.7 Effectiveness of the CONTRACTOR's process for handling member and provider grievances and complaints.

18.1.2 The audit may include, if indicated, tests for fraud and abuse on the part of the CONTRACTORS, such as:

18.1.2.1 Contract procurement fraud (provider credentials, financial solvency, inadequate network, bid-rigging)

18.1.2.2 Marketing and enrollment fraud (slamming, enrolling ineligible or non-existent members, cherry-picking, kickbacks, lemon-dropping)

18.1.2.3 Underutilization (delays, denials, unreasonable prior authorization requirements, gag orders to providers)

18.1.2.4 Claims submission and billing fraud (misrepresenting Medical Loss Ratios (MLRs), dual eligible scams, cost-shifting to carve-outs, misrepresenting kicker payment-eligible services or incentivized services, encounter data fraud)

- 18.1.3 These audits may be conducted using either internal audit and/or contracted audit staff, and will be conducted in accordance with Generally Accepted Governmental Auditing Standards. The Department will be responsible for developing the scope and protocols for the audit.
- 18.1.4 Audit findings indicative of non-compliance on the part of the CONTRACTORS may be addressed through corrective action plans and sanctions up to and including liquidated damages as specified in this contract. Nothing in this requirement is intended to duplicate or forestall any other audits of the CONTRACTORS required by this contract, the SC Department of Insurance (SCDOI), national standards, or CMS.

## **18.2 Liquidated Damages for Failure to Meet Contract Requirements**

- 18.2.1 The Department and the CONTRACTOR agree that in the event of the CONTRACTOR's failure to meet the requirements provided in this Contract and/or all documents incorporated herein, damage will be sustained by the Department and the actual damages which the Department will sustain in the event of and by reason of such failure are uncertain, and extremely difficult and impractical to ascertain and determine. The parties therefore agree that the CONTRACTOR shall be liable to the Department for liquidated damages in the fixed amounts stated in this Section of this Contract.
- 18.2.2 It is also agreed that the collection of liquidated damages by the Department shall be made without regard to any appeal rights the CONTRACTOR may have pursuant to this Contract.
- 18.2.3 The CONTRACTOR shall pay the Department liquidated damages in the amount of up to \$1,500.00 per day or up to \$10,000.00 per incident of noncompliance with any requirement stated in this Contract and/or all documents incorporated herein. The Department retains the discretion to choose the per day or per incident damages, taking into consideration the facts and circumstances surrounding CONTRACTOR's noncompliance.
- 18.2.3.1 The above Contract Section notwithstanding, liquidated damages for noncompliance with specific contract requirements identified in Table 18.1 are listed therein and supersede the general liquidated damages provision stated above.
- 18.2.4 The CONTRACTOR shall not be liable for liquidated damages if the CONTRACTOR would have been able to meet the Contract requirement but for the Department's failure to perform as provided in this Contract.
- 18.2.5 In the event an appeal by the CONTRACTOR regarding the application of liquidated damages under this Contract results in a decision in favor of the CONTRACTOR, any such funds paid by the CONTRACTOR or withheld by the Department shall be returned to the CONTRACTOR less any cost incurred by the Department.

18.2.6 Any liquidated damages assessed by the Department shall be due and payable to the Department within thirty (30) calendar days after the Department issues a notice of assessment. If payment is not made by the due date, the Department shall withhold the amount due from future monthly Capitation Payment(s).

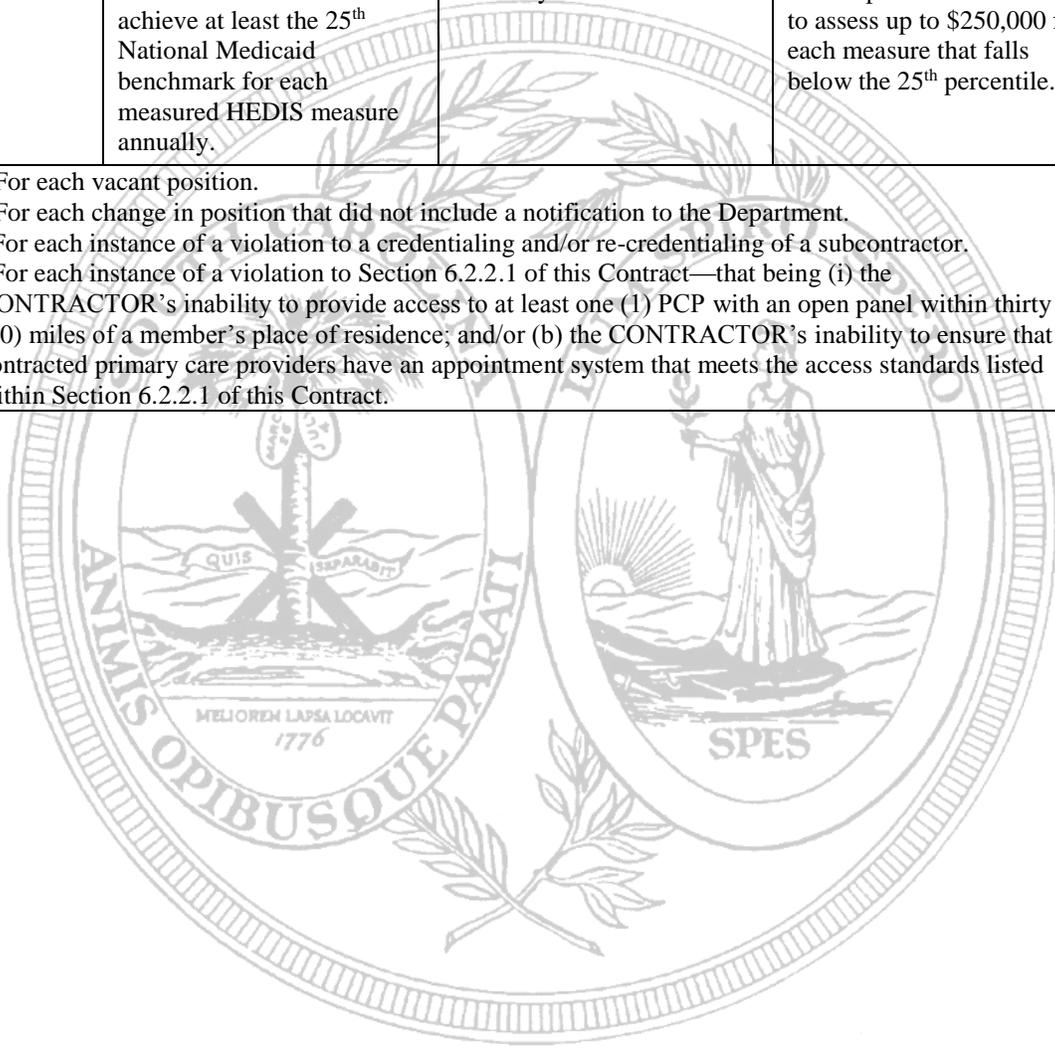
18.2.7 The Department reserves the right to publish information regarding the application of liquidated damages, in accordance with Department transparency initiatives.

**Table 18.1.** Liquidated Damages by Performance Measure, Frequency and Damage

Section #	PERFORMANCE MEASURE	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
2.2.2	CONTRACTOR's staff must include, but is not limited to the Key Personnel listed in Table 2.1.	Daily	The Department is entitled to assess up to \$5,000 per occurrence. <sup>1</sup>
2.2.2.3	CONTRACTOR shall notify the Department in writing of any changes in Key Personnel.	Daily	The Department is entitled to assess up to \$5,000 per occurrence. <sup>2</sup>
2.3.1	CONTRACTOR shall follow Department policy on credentialing/re-credentialing of subcontractors.	Varies by subcontractor type	The Department is entitled to assess up to \$5,000 per occurrence. <sup>3</sup>
2.4.2.2	CONTRACTOR shall submit each new subcontract template prior to execution of the subcontract.	As Templates are Updated	The Department is entitled to assess up to \$5,000 per occurrence.
3.8.3	CONTRACTOR shall maintain a Call Center that complies with all service level agreements specified in the contract section.	Daily/Monthly	The Department is entitled to assess up to \$1,500 per day.
4.7.7	CONTRACTOR shall implement a member pharmacy lock-in program to monitor member's use of prescription drugs.	Daily	The Department is entitled to assess up to \$5,000 per day.

Section #	PERFORMANCE MEASURE	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
6.2.2	CONTRACTOR must be able to provide primary care services by a contracted provider within the time and distance requirements of the contract.	Daily	The Department is entitled to assess up to \$5,000 per occurrence. <sup>4</sup>
6.2.3	CONTRACTOR shall comply with the stated timelines for submission of network adequacy reports.	Periodically	The Department is entitled to assess up to \$10,000 per day for late submissions.
7.4.7.1	CONTRACTOR shall pay 90% of clean claims within thirty (30) days of claim receipt.	Daily	The Department is entitled to assess up to \$5,000 per day.
7.4.7.2	CONTRACTOR shall pay 99% of clean claims within ninety (90) days of claim receipt.	Daily	The Department is entitled to assess up to \$5,000 per day.
11.4.1	CONTRACTOR must immediately report any suspicion or knowledge of fraud and abuse by its Medicaid Managed Care Members, employees, or subcontractors.	Daily	The Department is entitled to assess up to \$10,000 per occurrence.
11.10	CONTRACTOR must comply with provisions prohibiting payments to excluded and/or terminated providers.	Periodic	The Department is entitled to assess up to \$10,000 per occurrence.
14.2.1	CONTRACTOR must submit encounter data for paid or clinically denied services to the Department.		The Department is entitled to assess up to \$10,000 per day for missed submissions.
14.2.1.1	CONTRACTOR's encounter submission must be at least 97% accurately submitted.		The Department is entitled to assess up to \$10,000 per day for submissions that are below 97%.

Section #	PERFORMANCE MEASURE	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
14.3.1.3	The CONTRACTOR must correct and resubmit all previously denied encounter records within ninety (90) days after initial submission.		The Department is entitled to assess up to \$10,000 per day beyond 90 days, for submissions that are between 97% and 100%.
15.5.3	CONTRACTOR must achieve at least the 25 <sup>th</sup> National Medicaid benchmark for each measured HEDIS measure annually.	Annually	The Department is entitled to assess up to \$250,000 for each measure that falls below the 25 <sup>th</sup> percentile.
<p><sup>1</sup> For each vacant position.</p> <p><sup>2</sup> For each change in position that did not include a notification to the Department.</p> <p><sup>3</sup> For each instance of a violation to a credentialing and/or re-credentialing of a subcontractor.</p> <p><sup>4</sup> For each instance of a violation to Section 6.2.2.1 of this Contract—that being (i) the CONTRACTOR’s inability to provide access to at least one (1) PCP with an open panel within thirty (30) miles of a member’s place of residence; and/or (b) the CONTRACTOR’s inability to ensure that its contracted primary care providers have an appointment system that meets the access standards listed within Section 6.2.2.1 of this Contract.</p>			



### **18.3 Corrective Action Plan**

- 18.3.1 Department in its sole discretion may require the CONTRACTOR to submit corrective action plan (CAP) for any non-compliance activity.
- 18.3.2 The corrective action plan must include a date certain for correction of the problems that led to the occurrence along with interim milestones to be achieved, the criteria for determining that a milestone has been achieved, reporting objectives and schedule, staffing commitment and sufficiently detailed description for the Department to determine the appropriateness and effectiveness of the plan of correction.
- 18.3.3 Issues that are not substantially corrected by the dates agreed upon in the plan of correction will result in the original schedule of damages will be reinstated, including collection of damages for the corrective action period, and liquidated damages will continue until satisfactory correction of the occurrence, as determined by the Department, has been made.
- 18.3.4 Whenever the Department determines, based on identified facts and documentation, that the CONTRACTOR is failing to meet material obligations and performance standards described in this Contract, it may suspend the CONTRACTOR's right to enroll new Medicaid Managed Care Members and impose any other sanctions and/or liquidated damages in accordance with Section 18 of this Contract.
- 18.3.5 The Department, when exercising this option, shall notify the CONTRACTOR in writing of its intent to suspend new enrollment. The suspension period may be for any length of time specified by the Department, or may be indefinite. The Department also may notify Medicaid Managed Care Members of the CONTRACTOR's non-performance and permit these Medicaid Managed Care Members to transfer to another Health Plan following the implementation of suspension.

### **18.4 Sanctions**

- 18.4.1 If the Department determines that the CONTRACTOR has violated any provision of this Contract, or the applicable statutes or rules governing Medicaid Prepaid Health Plans, the Department may impose sanctions against the CONTRACTOR. The Department shall notify the CONTRACTOR and CMS in writing of its intent to impose sanctions and explain the CONTRACTOR's due process rights. Sanctions shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §§438.700-730 (2009, as amended) and may include any of the following:
- 18.4.1.1 Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. This violation may result in recoupment of the capitated payment;

- 18.4.1.2 Suspension of all marketing activities permitted under this Contract;
- 18.4.1.3 Imposition of a fine of up to Twenty-five Thousand Dollars (\$25,000.00) for each marketing/enrollment violation, in connection with any one audit or investigation;
- 18.4.1.4 Termination pursuant to Section 17 of this Contract;
- 18.4.1.5 Non-renewal of the Contract pursuant to Section 17 of this Contract;
- 18.4.1.6 Suspension of auto-enrollment;
- 18.4.1.7 Appointment of temporary management in accordance with §1932(e)(2)(B) of SSA (42 U.S.C. 1396u-2) (2001, as amended) and 42 CFR §438.702. If the State finds that the CONTRACTOR has repeatedly failed to meet substantive requirements in §1903(m) or §1932 of the Social Security Act (42 USC 1396u-2), the State must impose temporary management, grant members the right to terminate enrollment without cause and notify the affected members of their right to terminate enrollment;
- 18.4.1.8 Civil money penalties in accordance with §1932 of the Social Security Act (42USC 1396u-2);
- 18.4.1.9 Withholding of a portion or all of the CONTRACTOR's Capitation Payment;
- 18.4.1.10 Permitting individuals enrolled in the CONTRACTOR's plan to disenroll without cause. Department may suspend or default all enrollment of Medicaid Managed Care Members after the date the Secretary or Department notifies the CONTRACTOR of an occurrence under §1903(m) or § 1932(e) of the Social Security Act;
- 18.4.1.11 Terminating the Contract if the CONTRACTOR has failed to meet the requirements of sections 1903(m), 1905(t)(3) or 1932(e) of the Social Security Act and offer the CONTRACTOR's Medicaid Managed Care Members an opportunity to enroll with other CONTRACTORs to allow Medicaid Managed Care Members to receive medical assistance under the South Carolina State Plan for Medical Assistance. The Department shall provide the CONTRACTOR a hearing before the Department's Division of Appeals and Hearings before termination occurs. The Department will notify the Medicaid Managed Care Members enrolled in the CONTRACTOR's Health Plan of the hearing and allow the Medicaid Managed Care Members to disenroll, if they choose, without cause;
- 18.4.1.12 Imposition of sanctions pursuant to §1932(e)(B) of the Social Security Act if the CONTRACTOR does not provide abortion services as provided under the Contract at Section 4;

- 18.4.1.13 Imposition of a fine of up to Twenty-five Thousand Dollars (\$25,000) for each occurrence of the CONTRACTOR's failure to substantially provide Medically Necessary items and services that are required to be provided to a Medicaid Managed Care Member covered under the Contract and for misrepresentation or false statements to enrollees, potential enrollees or health care providers for failure to comply with physician incentive plans or marketing violations, including director or indirect distribution by the CONTRACTOR, its agent or independent CONTRACTOR of marketing materials that have not been approved by the State or that contain false or materially misleading information;
- 18.4.1.14 Imposition of a fine of up to Fifteen Thousand Dollars (\$15,000) per individual not enrolled and up to a total of One Hundred Thousand Dollars (\$100,000) per each occurrence, when the CONTRACTOR acts to discriminate among Medicaid Managed Care Members on the basis of their health status or their requirements for health care services. Such discrimination includes, but is not limited to, expulsion or refusal to re-enroll an individual, except as permitted by Title XIX, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services;
- 18.4.1.15 Imposition of a fine as high as double the excess amount charged to the Medicaid Managed Care Members by the CONTRACTOR for premiums or charges in excess of the premiums or charges permitted under Title XIX;
- 18.4.1.16 Imposition of sanctions as outlined in the Managed Care Policy and Procedure Manual if the CONTRACTOR fails to comply with the Physician Incentive Plan requirements;
- 18.4.1.17 Imposition of sanctions as outlined above if the CONTRACTOR misrepresents or falsifies information that it furnishes to CMS, to the State or to a Medicaid Managed Care Member, potential Medicaid Managed Care Member or Provider.
- 18.4.2 Unless the duration of a sanction is specified, a sanction will remain in effect until the Department is satisfied that the basis for imposing the sanction has been corrected. The Department will notify CMS when a sanction has been lifted.

### **18.5 Plan of Correction Required (Contract Non-Compliance)**

- 18.5.1 The CONTRACTOR and its Subcontractors shall comply with all requirements of this Contract. In the event the Department or its designee finds that the CONTRACTOR and/or its Subcontractors failed to comply with any requirements of this Contract, the CONTRACTOR shall be required to submit a plan of correction to the Department outlining the steps it will take to correct any deficiencies and/or non-compliance issues identified by Department in the Notice of Corrective Action along with interim milestones to be achieved, the criteria for determining that a milestone has been achieved, reporting objectives and schedule, staffing commitment and sufficiently detailed description for the Department to determine the appropriateness and effectiveness of the plan of correction.
- 18.5.1.1 The Department shall have final approval of the CONTRACTOR's plan of correction.
- 18.5.1.2 The Department will provide written notification to a CONTRACTOR, which it places under a Corrective Action Plan (CAP).
- 18.5.1.3 Further, to ensure transparency of operations, the Department will make a public announcement when it places the CONTRACTOR under a CAP.
- 18.5.1.4 The announcement will, at a minimum, be made via Provider Bulletin, media release and/or publication on the Department's web site.
- 18.5.2 The CONTRACTOR's plan of correction shall be submitted to Department within the time frame specified in the Notice of Corrective Action.
- 18.5.2.1 The CONTRACTOR and/or its Subcontractor(s) shall implement the corrective actions as approved by the Department and shall be in compliance with the Contract requirements noted within the time frame specified in the Notice of Corrective Action.
- 18.5.2.2 The CONTRACTOR and/or its Subcontractors shall be available and cooperate with the Department and/or its designee as needed in implementing the approved corrective actions.
- 18.5.3 Failure of the CONTRACTOR and/or its subcontractor(s) to implement and follow the plan of correction as approved by the Department shall subject the CONTRACTOR to the actions, stated in this contract including all subsections of this Contract.

## **19 TERMS AND CONDITIONS**

### **19.1 General Contractual Condition**

19.1.1 The CONTRACTOR agrees to comply with all state and federal laws, regulations, and policies as they exist as of the date of this Contract, or as later amended that are or may be applicable to this Contract, including those not specifically mentioned herein.

## **19.2 HIPAA Compliance**

19.2.1 The CONTRACTOR shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the rules and regulations promulgated thereunder (45 CFR Parts 160, 162, and 164).

19.2.2 The CONTRACTOR shall ensure compliance with all HIPAA requirements across all systems and services related to this contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

## **19.3 Safeguarding Information**

19.3.1 The CONTRACTOR shall establish written safeguards that restrict the use and disclosure of information concerning Medicaid Managed Care Members or potential members to purposes directly connected with the performance of this Contract. The CONTRACTOR's written safeguards shall:

19.3.1.1 Be at least as restrictive as those imposed by 42 CFR Part 431, Subpart F (2009, as amended) and 27 S.C. Code Regs. § 126-170 et seq. (Supp. 2009, as amended);

19.3.1.2 State that, in the event of a conflict between the CONTRACTOR's written safeguard standards and any other state or federal confidentiality statute or regulation, the CONTRACTOR shall apply the stricter standard;

19.3.1.3 Require the written consent of the Medicaid Managed Care Member or potential member before disclosure of information about him or her, except in those instances where state or federal statutes or regulations require disclosure or allow disclosure with the consent of the Medicaid Managed Care Member or potential Medicaid Managed Care Member;

19.3.1.4 Only allow the release of statistical or aggregate data that has been de-identified in accordance with federal regulations at 45 CFR § 164.514 and which cannot be traced back to particular individuals; and

19.3.1.5 Specify appropriate personnel actions to sanction violators.

## **19.4 HIPAA Business Associate**

19.4.1 Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed upon in Appendix C.

## **19.5 Release of Records**

19.5.1 The CONTRACTOR shall release medical records of Medicaid Managed Care Members, as may be authorized by the member, or as may be directed by authorized personnel of the Department, appropriate agencies of the State of South Carolina, or the United States Government.

19.5.2 Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Contract.

### **19.6 Confidentiality of Information**

19.6.1 The CONTRACTOR shall assure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the CONTRACTOR's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws. The CONTRACTOR shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.

19.6.2 All information as to personal facts and circumstances concerning members or potential members obtained by the CONTRACTOR shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the Department or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Contract.

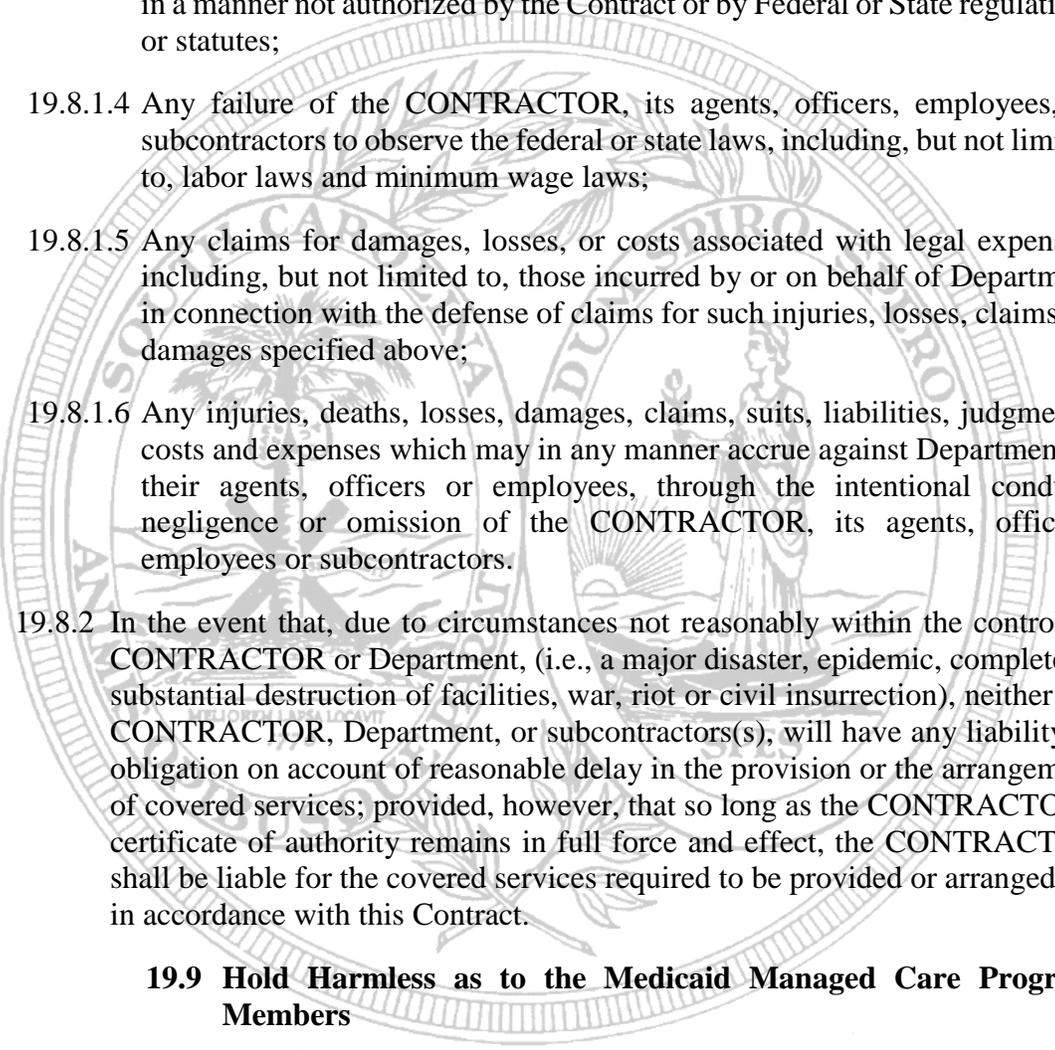
### **19.7 Integration**

19.7.1 This Contract shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

### **19.8 Hold Harmless**

19.8.1 The CONTRACTOR shall indemnify, defend, protect, and hold harmless Department and any of its officers, agents, and employees from:

19.8.1.1 Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the CONTRACTOR in connection with the performance of this Contract;

- 
- 19.8.1.2 Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or legal statutes, by CONTRACTOR, its agents, officers, employees, or subcontractors in the performance of this Contract;
- 19.8.1.3 Any claims for damages or losses resulting to any person or firm injured or damaged by CONTRACTOR, its agents, officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by Federal or State regulations or statutes;
- 19.8.1.4 Any failure of the CONTRACTOR, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
- 19.8.1.5 Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of Department in connection with the defense of claims for such injuries, losses, claims, or damages specified above;
- 19.8.1.6 Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against Department or their agents, officers or employees, through the intentional conduct, negligence or omission of the CONTRACTOR, its agents, officers, employees or subcontractors.
- 19.8.2 In the event that, due to circumstances not reasonably within the control of CONTRACTOR or Department, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the CONTRACTOR, Department, or subcontractors(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services; provided, however, that so long as the CONTRACTOR's certificate of authority remains in full force and effect, the CONTRACTOR shall be liable for the covered services required to be provided or arranged for in accordance with this Contract.

**19.9 Hold Harmless as to the Medicaid Managed Care Program Members**

19.9.1 In accordance with the requirements of S.C Code Ann. § 38-33-130(b) (Supp. 2001, as amended), and as a condition of participation as a health care provider, the CONTRACTOR hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Medicaid Managed Care Members of CONTRACTOR, or persons acting on their behalf, for health care services which are rendered to such members by the CONTRACTOR and its subcontractors, and which are covered benefits under the members evidence of coverage. This provision applies to all covered health care services furnished to the Medicaid Managed Care Member for which the State does not pay the CONTRACTOR or the State or the CONTRACTOR does not pay the individual or health care provider that furnishes the services under a contractual, referred, or other arrangement during the time the member is enrolled in, or otherwise entitled to benefits promised by the CONTRACTOR. The CONTRACTOR further agrees that the Medicaid Managed Care Member shall not be held liable for payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Department provided the service directly. The CONTRACTOR agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by CONTRACTOR and insolvency of CONTRACTOR. The CONTRACTOR further agrees that this provision shall be construed to be for the benefit of Medicaid Managed Care Members of CONTRACTOR, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the CONTRACTOR and such members, or persons acting on their behalf.

#### **19.10 Notification of Legal Action**

19.10.1 The CONTRACTOR shall give the Department notification in writing by certified mail within five (5) business days of being notified of any administrative legal action or complaint filed and prompt notice of any claim made against the CONTRACTOR by a Subcontractor or Medicaid Managed Care Member which may result in litigation related in any way to this Contract.

#### **19.11 Non-Discrimination**

19.11.1 The CONTRACTOR agrees that no person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of the CONTRACTOR's MCO program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the CONTRACTOR. The CONTRACTOR shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all subcontracts.

#### **19.12 Safety Precautions**

19.12.1 The Department and HHS assume no responsibility with respect to accidents, illnesses, or claims arising out of any activity performed under this Contract. The CONTRACTOR shall take necessary steps to ensure or protect its clients, itself, and its personnel. The CONTRACTOR agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

### **19.13 Loss of Federal Financial Participation (FFP)**

19.13.1 The CONTRACTOR hereby agrees to be liable for any loss of FFP suffered by Department due to the CONTRACTOR's, or its subcontractors', failure to perform the services as required under this Contract. Payments provided for under this Contract will be denied for new Medicaid Managed Care Members when, and for so long as, payment for those Medicaid Managed Care Members is denied by CMS in accordance with the requirements in 42 CFR §438.730.

### **19.14 Sharing of Information**

19.14.1 The CONTRACTOR understands and agrees that Department and SCDOI may share any and all documents and information, including confidential documents and information, related to compliance with this Contract and any and all South Carolina insurance laws applicable to Health Maintenance Organizations (HMO). The CONTRACTOR further understands and agrees that the sharing of information between Department and SCDOI is necessary for the proper administration of the Medicaid Managed Care Program.

### **19.15 Applicable Laws and Regulations**

19.15.1 The CONTRACTOR agrees to comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

- 19.15.1.1 Title XIX of the Social Security Act and Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);
- 19.15.1.2 S.C. Code Ann. §38-33-10 et. seq. (Supp. 2000, as amended) and 25A S.C. Code Ann. Regs. §69-22 (Supp. 2000, as amended);
- 19.15.1.3 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.) and 20 USC §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);
- 19.15.1.4 Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and regulations issued pursuant thereto, (45 CFR Part 80), which provide that the CONTRACTOR must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract;

- 19.15.1.5 Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;
- 19.15.1.6 Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. §794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;
- 19.15.1.7 The Age Discrimination Act of 1975, as amended, 42 U.S.C §6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;
- 19.15.1.8 The Omnibus Budget Reconciliation Act of 1981, as amended, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;
- 19.15.1.9 The Balanced Budget Act of 1997, as amended, P.L. 105-33, and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;
- 19.15.1.10 The Americans with Disabilities Act, as amended, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;
- 19.15.1.11 Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusion of CONTRACTORS for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;
- 19.15.1.12 The Drug Free Workplace Acts, S.C. Code Ann. §44-107-10 et seq. (Supp. 2000, as amended), and the Federal Drug Free Workplace Act of 1988 as set forth in 45 CFR Part 82 (2008, as amended); and
- 19.15.1.13 Title IX of the Education Amendments of 1972 regarding education programs and activities.

#### **19.16 Independent Contractor**

- 19.16.1 It is expressly agreed that the CONTRACTOR and any Subcontractors and agents, officers, and employees of the CONTRACTOR or any Subcontractors in the performance of this Contract shall act in an independent capacity and not as officers and employees of the Department or the State of South Carolina.
- 19.16.2 It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the CONTRACTOR or any Subcontractor and the Department and the State of South Carolina.

#### **19.17 Governing Law and Place of Suit**

19.17.1 It is mutually understood and agreed that this Contract shall be governed by the laws of the State of South Carolina both as to interpretation and performance. Any action at law, suit in equity, or judicial proceeding for the enforcement of this Contract or any provision thereof shall be instituted only in the courts of the State of South Carolina.

#### **19.18 Severability**

19.18.1 If any provision of this Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the Department and the CONTRACTOR shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed.

19.18.2 In addition, if the laws or regulations governing this Contract should be amended or judicially interpreted as to render the fulfillment of the Contract impossible or economically infeasible, both the Department and the CONTRACTOR will be discharged from further obligations created under the terms of the Contract. To this end, the terms and conditions defined in this Contract can be declared severable.

#### **19.19 Copyrights**

19.19.1 If any copyrightable material is developed in the course of or under this Contract, the Department shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for Department purposes.

#### **19.20 Subsequent Conditions**

19.20.1 The CONTRACTOR shall comply with all requirements of this Contract and the Department shall have no obligation to enroll any Medicaid Managed Care Members into the CONTRACTOR's Health Plan until such time as all of said requirements have been met.

#### **19.21 Incorporation of Schedules/Appendices**

19.21.1 All schedules/appendices referred to in this Contract are attached hereto, are expressly made a part hereof, and are incorporated as if fully set forth herein.

#### **19.22 Titles**

19.22.1 All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

#### **19.23 Political Activity**

19.23.1 None of the funds, materials, property, or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

19.23.2 CONTRACTOR shall also comply with Byrd Anti-Lobbying Amendment and shall file the require certification that each tier will not use Federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any Federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any Federal award. Such disclosure are forwarded form tier to tier up to the recipient (45 CFR part 93). The CONTRACTOR shall ensure that that Federal funds have not been used for lobbying.

#### **19.24 Force Majeure**

19.24.1 The CONTRACTOR shall not be liable for any excess costs if the failure to perform the Contract arises out of causes beyond the control and without the fault or negligence of the CONTRACTOR. Such causes may include, but are not restricted to, acts of God or of the public enemy; acts of the Government in either its sovereign or contractual capacity; fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather; but in every case the failure to perform must be beyond the control and without the fault or negligence of the CONTRACTOR. If the failure to perform is caused by default of a subcontractor, and if such default arises out of causes beyond the control of both the CONTRACTOR and subcontractor, and without the fault or negligence of either of them, the CONTRACTOR shall not be liable for any excess costs for failure to perform, unless the supplies or services to be furnished by the subcontractors were obtainable from other sources in sufficient time to permit the CONTRACTOR to meet the required delivery schedule.

19.24.2 The Department shall not be liable for any excess cost to the CONTRACTOR for Department's failure to perform the duties required by this Contract if such failure arises out of causes beyond the control and without the result of fault or negligence on the part of Department. In all cases, the failure to perform must be beyond the control and without the fault or negligence of Department.

#### **19.25 Conflict of Interest**

19.25.1 The CONTRACTOR represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The CONTRACTOR further covenants that, in the performance of the Contract, no person having any such known interests shall be employed.

## **19.26 Department Policies and Procedures**

19.26.1 The CONTRACTOR shall comply with the applicable policies and procedures of the Department, specifically including without limitation the policies and procedures for Medicaid Managed Care services, and all policies and procedures applicable to each category of Covered Benefits and the services related to the delivery of those Covered Benefits as required by the terms of this Contract. In no instance may the CONTRACTOR impose limitations or exclusions with respect to Covered Benefits and related services that are more stringent than those specified in the Department's applicable Managed Care Policies and Procedures. The Department will use best efforts to provide prior written notice to CONTRACTOR of applicable material changes to its policies and procedures that alter the terms of this Contract.

## **19.27 State and Federal Law**

19.27.1 At all times during the term of this Contract and in the performance of every aspect of this Contract, the CONTRACTOR shall strictly adhere to all applicable federal and state law (statutory and case law), regulations and standards, in effect when this Contract is signed or which may come into effect during the term of this Contract.

19.27.2 The CONTRACTOR shall implement any change mandated by the Affordable Care Act (ACA), which may pertain to MCOs and/or Medicaid Services. One such requirement listed in Section 2501 of ACA pertains to the states collecting drug rebates for drugs covered under a MCO. The CONTRACTOR shall create and transmit a file according to the Department's format that will allow for the Department or its subcontractors/vendors to bill drug rebates to manufacturers. The CONTRACTOR shall fully cooperate with the Department and the Department's subcontractors/vendors to ensure file transmissions are complete, accurate and delivered by the Department's specified deadlines. In addition, the CONTRACTOR shall assist and provide detailed Claim information requested by the Department or the Department's subcontractors/vendors to support rebate dispute and resolution activities. The Department will review the ACA requirements and if it determines the new requirements will significantly increase cost to the CONTRACTOR, the Department will work with its actuary to adjust the CONTRACTOR's Capitation Payment at the next scheduled rate adjustment.

## **19.28 Contractor's Appeal Rights**

19.28.1 If any dispute shall arise under the terms of this Contract, the sole and exclusive remedy shall be the filing of a Notice of Appeal within thirty (30) calendar days of receipt of written notice of Department's action or decision that forms the basis of the appeal. Administrative appeals shall be in accordance with 27 S.C. Code Ann. Regs. §126-150, et seq.(1976, as amended), and the Administrative Procedures Act, S.C. Code Ann. § 1-23-310, et seq. (1976, as amended). Judicial review of any final Department administrative decisions shall be in accordance with S.C. Code Ann. § 1-23-380 (1976, as amended).

### **19.29 Collusion/Anti-Trust**

19.29.1 Any activities undertaken by CONTRACTOR that may be construed as collusion or otherwise in violation of any federal or state anti-trust laws may result in termination of this Contract and/or referral to the Attorney General's Office.

### **19.30 Inspection of Records**

19.30.1 The CONTRACTOR shall make all program and financial records and service delivery sites open to the HHS, the Department, GAO, the State Auditor's Office, the Office of the Attorney General, the Comptroller General, or their designee or any representatives, shall have access to any books, documents, papers, and records of the CONTRACTOR which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts, and transcriptions. HHS awarding agencies, the HHS Inspector General, the U.S. Comptroller General, or any of their duly authorized representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of CONTRACTOR that are pertinent to the awards, in order to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to a recipient's personnel for the purpose of interview and discussion related to such documents. The rights of access in this paragraph are not limited to the required retention period, but shall last as long as records are retained. HHS, the Department, GAO, the State Auditor's Office, the Office of the Attorney General, the Comptroller General and/or their designees shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with CONTRACTOR clients and employees, and do on-site reviews of all matters relating to service delivery as specified by this Contract.

### **19.31 Non-Waiver of Breach**

19.31.1 The failure of the Department at any time to require performance by the CONTRACTOR of any provision of this Contract, or the continued payment of the CONTRACTOR by the Department, shall in no way affect the right of Department to enforce any provision of this Contract; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable.

19.31.2 Waiver of any breach of any term or condition in this Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

### **19.32 Non-Assignability**

19.32.1 No assignment or transfer of this Contract or of any rights hereunder by the CONTRACTOR shall be valid without the prior written consent of the Department.

### **19.33 Legal Services**

19.33.1 No attorney-at-law shall be engaged through use of any funds provided by the Department pursuant to the terms of this Contract. Further, with the exception of attorney's fees awarded in accordance with S.C. Code Ann. § 15-77-300, the Department shall under no circumstances become obligated to pay an attorney's fee or the costs of legal action to the CONTRACTOR. This covenant and condition shall apply to any and all suits, legal actions, and judicial appeals of whatever kind or nature to which the CONTRACTOR is a party.

### **19.34 Attorney's Fees**

19.34.1 In the event that the Department shall bring suit or action to compel performance of or to recover for any breach of any stipulation, covenant, or condition of this Contract, the CONTRACTOR shall and will pay to the Department such attorney's fees as the court may adjudge reasonable in addition to the amount of judgment and costs.

### **19.35 Retention of Records**

19.35.1 The CONTRACTOR shall retain records in accordance with 45 CFR § 74.53 including, but not limited to financial records, supporting documents, statistical records, and all other records pertinent to an award. Such records shall be retained for a period of three years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following:

19.35.1.1 If any litigation, claim, financial management review, or audit is started before the expiration of the 3-year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

19.35.1.2 Records for real property and equipment acquired with Federal funds shall be retained for 3-years after final disposition.

19.35.1.3 When records are transferred to or maintained by the HHS awarding agency, the 3-year retention requirement is not applicable to the recipient.

19.35.1.4 Indirect cost rate proposals, cost allocations plans, etc., as specified in Sec. 74.53(g).

19.35.2 Retain Records in accordance with requirements of 45 CFR Part 74 (3 years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original 3 year period ends). HIPAA now requires 5-year record retention.

**IN WITNESS WHEREOF, the Department and the CONTRACTOR, by their authorized agents, have executed this Contract as of the first day of July 2014.**

SOUTH CAROLINA DEPARTMENT  
OF  
HEALTH AND HUMAN SERVICES  
"SCDHHS"

"CONTRACTOR"

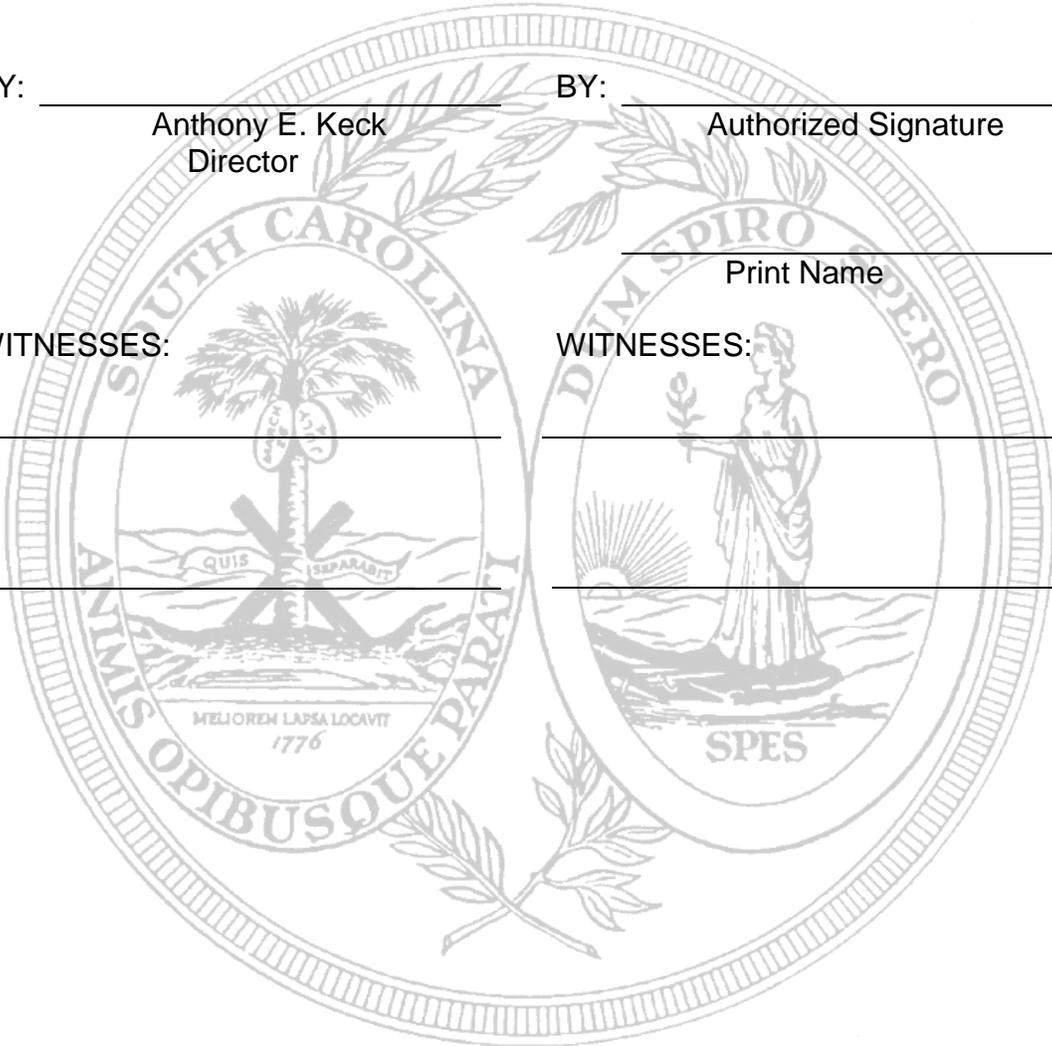
BY: \_\_\_\_\_  
Anthony E. Keck  
Director

BY: \_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Print Name

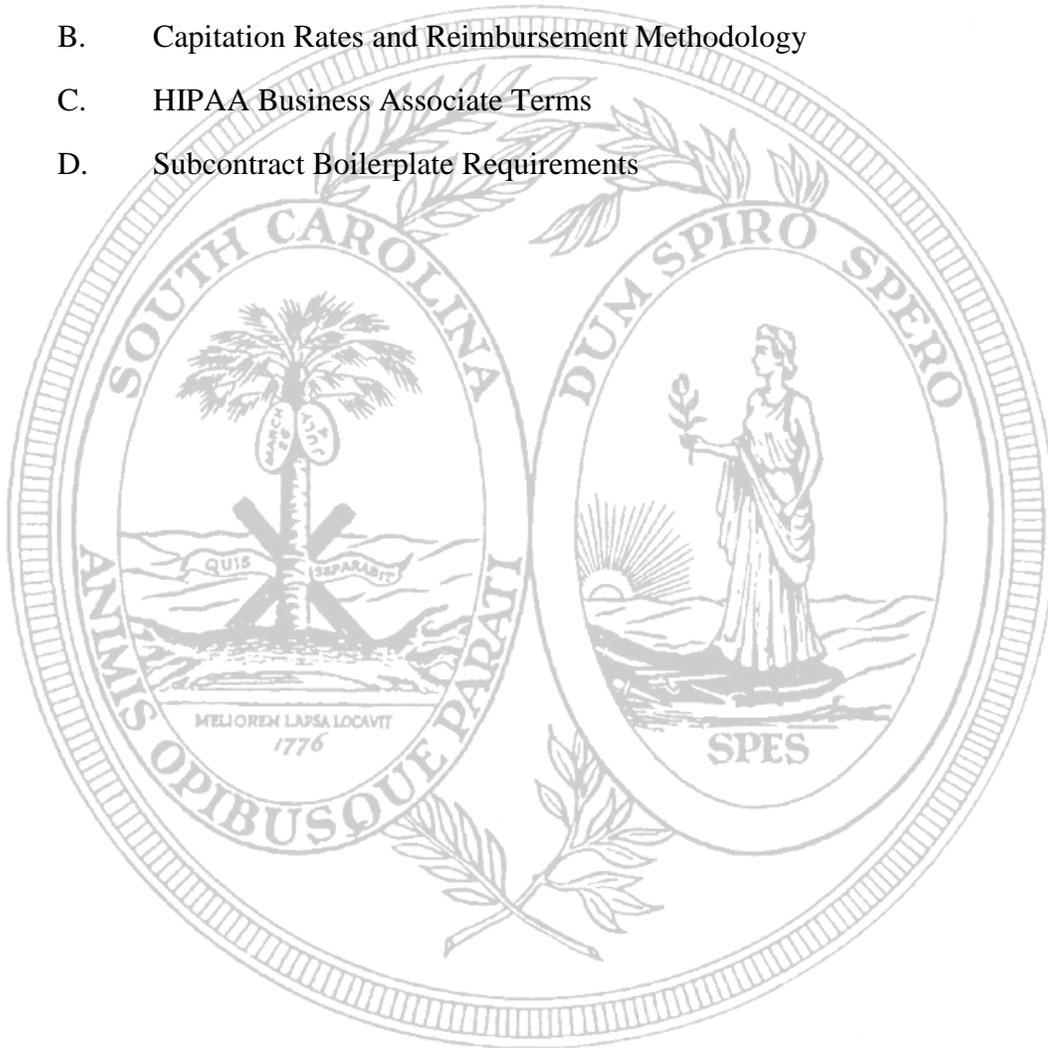
WITNESSES:  
\_\_\_\_\_  
\_\_\_\_\_

WITNESSES:  
\_\_\_\_\_  
\_\_\_\_\_



## LIST OF APPENDICES

- A. Definitions
- B. Capitation Rates and Reimbursement Methodology
- C. HIPAA Business Associate Terms
- D. Subcontract Boilerplate Requirements





APPENDIX A.  
Definitions

Listed below are the Definitions, Acronyms, and Abbreviations used in this Contract. These terms utilize the meaning used in the Department's rules and regulations. However, the following terms, when used in this Contract shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation. In the event of a conflict in language between these Definitions, Attachments, and other Sections of this Contract, the specific language in the Contract shall govern.



## APPENDIX A – DEFINITION OF TERMS AND ACRONYMS

### AAFP

Academy of Family Physicians.

### Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

### ACIP

Centers for Disease Control Advisory Committee on Immunization Practices.

### Action

The denial or limited authorization of a requested service, including the type or level of service;

- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the State;
- The failure of the CONTRACTOR to act within the timeframes provided in this Contract; or
- For a resident of a rural area with only one MCO, the denial of a Medicaid member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the CONTRACTOR's network.

### Administrative Days

Inpatient hospital days associated with nursing home level patients who no longer require acute care and are waiting for nursing home placement. Administrative days must follow an acute inpatient stay.

### Actuarially sound capitation rates

Capitation rates that:

- (1) Have been developed in accordance with generally accepted actuarial principles and practices;
- (2) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- (3) Have been certified, as meeting the requirements of this paragraph, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

### Additional Services

A covered service provided by the CONTRACTOR which is currently a non-covered service(s) by the SC State Plan for Medical Assistance or is an additional Medicaid covered service furnished by the CONTRACTOR to Medicaid Managed Care Program members for which the CONTRACTOR receives no additional capitated payment, and is offered to members in accordance with the standards and other requirements set forth in this Contract.

Adjustments to smooth data

Adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

AFDC/Family Independence

Aid to Families with Dependent Children.

American National Standards Institute (ANSI)

The American National Standards Institute is a private non-profit organization that oversees the development of voluntary consensus standards for products, services, processes, systems, and personnel in the United States.

ANSI ASC X12N 837P

The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837P (Professional) Version 5010A1 is the current electronic claim version.

Appeal

A request for review of an action, as “action” is defined in 42 C.F.R. §438.400.

Applicant

An individual seeking Medicaid eligibility through written application.

Benefit(s)

The health care services set forth in this Contract, for which the CONTRACTOR has agreed to provide, arrange, and be held fiscally responsible.

Bonus

15.5.3.1 A Bonus Pool is a payment that involves undistributed funds accumulated from Withhold amounts forfeited by the CONTRACTORS.

Business Days

Monday through Friday from 9 A.M. to 5 P.M., excluding State holidays.

CAHPS

The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of patients’ experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality.

Calendar Days

All seven days of the week (i.e., Monday, Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday).

CFR

Code of Federal Regulations.

CPT

Current Procedural Terminology, fourth edition, revised 2007.

Capitation Payment

The monthly payment by the Department to a CONTRACTOR for each enrolled Medicaid Managed Care Program member for the provision of benefits during the payment period.

Care Coordination

The manner or practice of planning, directing and coordinating health care needs and services of Medicaid Managed Care Program members.

Care Coordinator

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

Case

An event or situation

Case Manager

The individual responsible for identifying and coordinating services necessary to meet service needs of Medicaid Managed Care Program members.

Centers for Medicare & Medicaid Services (CMS)

The federal Agency within the U.S. Department of Health and Human Services with responsibility for the Medicare, Medicaid and the State Children's Health Insurance Program.

Certificate of Coverage

The term describing services and supplies provided to Medicaid Managed Care Program members, 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".

Claim

A bill for services, a line item of services, or all services for one recipient within a bill.

Clean Claim

Claims that can be processed without obtaining additional information from the Provider of the service or from a third party.

Clinical Risk Grouping (CRG)

The 3M Clinical Risk Groups (CRGs) are a risk-adjustment tool and clinically based classification system used to measure a population's burden of illness. 3M CRGs use standard claims data and, when available, additional data—such as pharmaceutical data and functional health status—collected longitudinally to assign each individual to a single, mutually exclusive risk group. Clinical Risk Groups categorize patients according to their risk of debility and expected future resource use, using diagnosis codes, procedure codes, and pharmacy claims. CRGs were developed in an intensively iterative process that relied on the creation of mutually exclusive risk groups. Although the CRGs algorithm is complex, the end result is a system of conceptually straightforward, clinically meaningful categories. The CRG system has predictive capability comparable to other prospective risk-adjustment systems. CRGs are therefore potentially useful not only as a basis for capitation-based payment systems but also as a tool for managing healthcare information. CRGs classify individuals in a range from 1 (healthy) to 9 (catastrophic). Medicaid beneficiaries with a CRG of 5 and above (complex conditions) require a coordination plan to address their needs from the health care plan.

### CMS

#### Centers for Medicare & Medicaid Services

### CMS 1500

Universal claim form, required by CMS, to be used by non-institutional and institutional CONTRACTORS that do not use the UB-92.

### Cold-call Marketing

Any unsolicited personal contact by the CONTRACTOR (“MCO”) with a potential member for the purpose of marketing.

### Co-payment

Any cost-sharing payment for which the Medicaid Managed Care Program member is responsible for in accordance with 42 CFR §447.50.

### Comprehensive Risk Contract

A risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services: (1) Outpatient hospital services; (2) Rural health clinic services; (3) FQHC services; (4) Other laboratory and X-ray services; (5) Nursing facility (NF) services; (6) Early and periodic screening, diagnostic, and treatment (EPSDT) services; (7) Family planning services; (8) physician services; and (9) Home health services.

### Contract Dispute

A circumstance whereby the CONTRACTOR and Department are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under this Contract.

### Core Benefits

A schedule of health care benefits provided to Medicaid Managed Care Program members enrolled in the CONTRACTOR's plan as specified under the terms of this Contract.

Corrective Action Plan (CAP):

A narrative of steps taken to identify the most cost effective actions that can be implemented to correct errors causes. The Department's requirements include, but are not limited to:

- Details of all issues and discrepancies between specific contractual, programmatic and/or security requirements and the CONTRACTOR's policies, practices and systems.
- The CAP must also include timelines for corrective actions related to all issues or discrepancies identified, and be submitted to the Department for review and approval.

Cost Neutral

The mechanism used to smooth data, share risk, or adjust for risk that will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

Covered Services

Services included in the South Carolina State Plan for Medical Assistance.

Continuity of Care

Activities that ensure a continuum approach to treating and providing health care services to Medicaid Managed Care Members consistent with 42 CFR 438.208, the provisions outlined in this Contract and the Managed Care Policy and Procedure Manual. This includes, but is not limited to:

- Ensuring appropriate referrals, monitoring, and follow-up to providers within the network,
- Ensuring appropriate linkage and interaction with providers outside the network.
- Processes for effective interactions between Medicaid Managed Care Members, in-network and out-of-network providers and identification and resolution of problems if those interactions are not effective or do not occur..

CONTRACTOR

The domestic licensed HMO ("MCO") that has executed a formal agreement with Department to enroll and serve Medicaid Managed Care Program members under the terms of this 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.

Credentialing

The CONTRACTOR's determination as to the qualifications and ascribed privileges of a specific Provider to render specific health care services.

Credible Allegation of Fraud

An allegation, which has been verified by the State, from any source, including, but not limited to: fraud hotline complaints; claims data mining; patterns identified through provider audits; civil false claims cases; and law enforcement investigations.

Cultural Competency

A set of interpersonal skills that promote the delivery of services in a culturally competent manner to all Medicaid Managed Care Members—including those with limited English proficiency and diverse cultural and ethnic backgrounds—allowing for individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Medicaid Managed Care Members (as required by 42 CFR §438.206).

DAODAS

Department of Alcohol and Other Drug Abuse Services.

DDSN

Department of Disabilities and Special Needs.

DHEC

Department of Health and Environmental Control.

Days

Calendar days unless otherwise specified.

Department

South Carolina Department of Health and Human Services (SCDHHS)

Disenrollment

Action taken by Department or its designee to remove a Medicaid Managed Care member from the CONTRACTOR's plan following the receipt and approval of a written request for disenrollment or a determination made by Department or its designee that the member is no longer eligible for Medicaid or the Medicaid Managed Care Program.

Direct Marketing/Cold Call

Any unsolicited personal contact with or solicitation of Medicaid applicants/eligibles in person, through direct mail advertising or telemarketing by an employee or agent of the CONTRACTOR (“MCO”) for the purpose of influencing an individual to enroll with the MCO (“Health Plan”).

Department Appeal Regulations

Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 and S.C. Code Ann. §§1-23-310 et seq. (2006, as amended).

DRG

Diagnosis-Related Group

Dual Eligible (aka Dual Eligibles)

Individuals that are enrolled in both Medicaid and Medicare programs and receive benefits from both programs.

Dual Diagnosis/Dual Disorders

An individual who has both a diagnosed mental health problem and a problem with alcohol and/or drug use.

EPSDT

An 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 SC State Plan for Medical Assistance under Title XIX.

Emergency Medical Condition

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 and/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:

- Furnished by a provider that is qualified to furnish these services under this title; and
- Needed to evaluate or stabilize an emergency medical condition.

Encounter

Any service provided to a Medicaid Managed Care Member regardless of how the service was reimbursed and regardless of provider type, practice specialty, or place of services. This would include expanded services/benefits as defined in this Contract.

Enrollee

A Medicaid beneficiary who is currently enrolled in the State's Medicaid Managed Care Program, specifically a Managed Care Organization (MCO). Other Managed Care Programs may include, but are not limited to: PIHP, PAHP, or PCCM (42 CFR §438.10 (a)).

Enrollment

The process in which a Medicaid eligible selects or is assigned to an MCO and goes through a managed care educational process as provided by the Department or its agent.

Enrollment (Voluntary)

The process in which an applicant/recipient selects a CONTRACTOR and goes through an educational process to become a Medicaid Managed Care Member of the CONTRACTOR.

Exclusion

Items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

External Quality Review (EQR)

The analysis and evaluation by an EQRO of aggregated information on quality, timeliness, and access to the health care services that an MCO or its CONTRACTORS furnish to Medicaid recipients.

External Quality Review Organization (EQRO)

An organization that meets the competence and independence requirements set forth in 42 CFR §438.354, and performs external quality review, other EQR-related activities set forth in 42 CFR §438.358, or both.

Evidence of Coverage - The term which describes services and supplies provided to Medicaid Managed Care 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".

Federal Poverty Level (FPL)

A measure of income level issued annually by the Department of Health and Human Services.

Federal Financial Participation (FFP)

Any funds, either title or grant, from the Federal Government.

Full-Time Equivalent (FTE)

A full time equivalent position.

FQHC

A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that 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.

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.

Fee-for-Service 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. This includes any act that constitutes fraud under applicable Federal or State law.

GAO

General Accounting Office.

Geographic Service Area

Each of the forty-six (46) Counties that comprise the State of South Carolina.

Grievance

Means an expression of dissatisfaction about any matter other than an action. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO level. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.)

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; with appropriate licensure or certification with the state of South Carolina.

HCPCS

CMS's Common Procedure Coding System.

Health Maintenance Organization (HMO; aka CONTRACTOR)

A domestic licensed organization that provides or arranges for the provision of basic and supplemental health care services for members in the manner prescribed by the South Carolina State Department of Insurance and qualified by CMS.

Healthcare Effectiveness Data and Information Set (HEDIS)

Standards for the measures are set by the NCQA.

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.

#### HHS or DHHS

United States Department of Health and Human Services.

#### Home and Community Based Services (HCBS)

In-home or community-based support services that assist persons with long term care needs to remain at home as authorized in an approved 1915(c) Waiver or 1915(i) State Plan.

#### Hospital Swing Beds

Hospitals participating in both the Medicaid and Medicare Programs, in addition to providing an inpatient hospital level of care may also provide nursing facility levels of care and be reimbursed as “swing bed” hospitals. A swing bed hospital must be located in a rural area, have fewer than one hundred (100) inpatient beds exclusive of newborn and intensive care type beds, and be surveyed for compliance by DHEC and certified as meeting Federal and State requirements of participation for swing bed hospitals.

#### ICD-CM

International Classification of Disease—Clinical Modification.

#### Incentive Arrangement

Any payment mechanism under which a CONTRACTOR may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

#### Inmate

On who is housed in or confined to a correctional facility (e.g. prison, prison facility, jail etc.) This does not include individuals on Probation or Parole or who are participating in a community program.

#### Inquiry

A routine question/s about a benefit. An inquiry does not automatically invoke a plan sponsor's grievance or coverage determination process.

#### Insolvency

A financial condition in which a CONTRACTOR's assets are not sufficient to discharge all its liabilities or when the CONTRACTOR is unable to pay its debts as they become due in the usual course of business.

#### Institutional Long Term Care

A system of health and social services designed to serve individuals who have functional limitations, which impair their ability to perform activities of daily living (ADL's). It is care or services provided in a facility that is licensed as a nursing facility, or a hospital that provides swing bed or administrative days.

### MMIS

Medicaid Management Information System.

### Managed Care Organization

An entity that has, or is seeking to qualify for, a comprehensive risk contract that is:

- A Federally qualified HMO that meets the advance directive requirements of subpart I of 42CFR Part 489; or
- 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 serviced 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", "Managed Care Organization (MCO)", "Health Plan", "Plan", or "Health Maintenance Organization (HMO)".

### Marketing

Any communication approved by the Department, from a CONTRACTOR to a Medicaid recipient who is not enrolled in that entity, that can be reasonably interpreted as intended to influence the recipient to enroll in that particular MCO Medicaid product, or either to not enroll, or to disenroll from, another Medicaid Managed Care product.

### Marketing Materials

Materials that:

- Are produced in any means, by or on behalf of an MCO, and
- Can be reasonably 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 recipients 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 Fraud Control Unit (MFCU)

The division of the State Attorney General’s Office that is responsible for the investigation and prosecution of provider fraud.

Medicaid Recipient Fraud Unit (MRFU)

The division of the State Attorney General’s Office that is responsible for the investigation and prosecution of recipient fraud.

Medicare

A federal health insurance program for people 65 or older and certain individuals with disabilities.

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.

Medical Necessity

The service (the provision of which may be limited by specific manual provisions, bulletins, and other directives) is directed toward the maintenance, improvement, or protection of health or toward the diagnosis and treatment of illness or disability.

Member or Medicaid Managed Care Member

An eligible person(s) who is currently enrolled with a Department approved Medicaid Managed Care CONTRACTOR. Throughout this Contract, this term is used interchangeably with “Enrollee” and “Beneficiary”.

Member Incentive

Incentives to encourage a Medicaid Managed Care Member to change or modify behaviors or meet certain goals.

Minimum Performance Standards (MPS)

The CONTRACTOR is expected to meet a minimum level of performance as identified in the Managed Care Policy and Procedure Manual—a specific list of quality metrics (*aka* the Withhold Metrics). These minimum levels of performance are referred to as the Minimum Performance Standards (MPS).

NCQA

The National Committee for Quality Assurance is a private, 501(c)(3) non-for-profit organization founded in 1990, and dedicated to improving health care quality.

NDC

National Drug Code.

National Practitioner Data Bank

A central repository for adverse action and medical malpractice payments. (1-800-767-6732)

Newborn

A live child born to a member during her membership or otherwise eligible for voluntary enrollment under this Contract.

Non-Contract Provider

Providers that are licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency that have not contracted with or are not employed by the CONTRACTOR to provide health care services.

Non-Covered Services

Services not covered under the SC State Plan for Medical Assistance.

Non-Emergency

An encounter with a health care provider by a Medicaid Managed Care Program member who has presentation of medical signs and symptoms that do not require immediate medical attention.

Non-Participating Physician

A physician licensed to practice who has not contracted with or is not employed by the CONTRACTOR to provide health care services.

Excluded Services

Medicaid services not included in the CONTRACTOR's Core Benefits and reimbursed fee-for-service by the State. Refer to the Managed Care Policy and Procedure Manual for additional details.

Overpayment

Any payment made to a provider that: is in excess of the amount allowable for the services furnished; does not follow current payment policy or rates; is an improper payment for the reasons established under 42 CFR § 431.960; and/or should not have otherwise been made to the provider.

Ownership Interest

The possession of, equity in the capital, the stock, or the profits of the entity. For further definition see 42 CFR § 455.101 (2009 as amended).

Performance Improvement Projects (PIP)

Projects designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.. In accordance with 42 CFR 438.240 the PIP must involve the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;

- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

#### Prepaid Ambulatory Health Plan (PAHP)

An entity that:

- Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
- Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
- Does not have a comprehensive risk contract.

#### Prepaid Inpatient Health Plan (PIHP)

An entity that:

- Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates;
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
- Does not have a comprehensive risk contract.

#### Plan (aka Health Plan)

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

#### Policies

The general principles by which the Department is guided in its management of the Title XIX program, as further defined by Department promulgations and state and 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.

#### Preventative and Rehabilitative Services for Primary Care Enhancement

A package of services designed to help maximize the treatment benefits/outcomes for those patients who have serious medical conditions and/or who exhibit lifestyle, psycho-social, and/or environmental risk factors.

#### Primary Care Services

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 Provider (PCP)

A general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician who serves as the entry point into the health care system for the member. The PCP is responsible for providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining continuity of care.

### Prior Authorization

The act of authorizing specific approved services by the CONTRACTOR before rendered.

### Program

The method of provision of Title XIX services to South Carolina recipients as provided for in the SC State Plan for Medical Assistance and Department regulations.

### Provider

A provider includes:

- Any individual, group, physicians (such as but not limited includes Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Outpatient Center (free standing or owned) Clinics and Laboratories) furnishing Medicaid services under an agreement with the Medicaid agency; or
- For the Medicaid Managed Care Program, any individual, group, physicians (including but not limited to Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary providers, Clinics, Outpatient Centers (free standing or owned) and Laboratories) 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.

### Provider Incentives or Provider-Designated Incentives

Provider-designated incentives are those incentives paid by the CONTRACTOR to qualified Providers for achieving designated goals. Provider-designated incentives are paid for the programs listed in the Managed Care Policy and Procedure Manual

### Quality

As related to external quality review, the degree to which a CONTRACTOR increases the likelihood of desired health outcomes of its enrollees through structural and operational characteristics and the provision of health services consistent with current professional knowledge.

### Quality Assessment

Measurement and evaluation of success of care and services offered to individuals, groups or populations

### Quality Assessment and Performance Improvement (QAPI)

Activities aimed at improving in the quality of care provided to enrolled members through established quality management and performance improvement processes

### Quality Assurance Committee

A variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.) that represent a CONTRACTOR's participating network of Providers—including representation from the CONTRACTOR's management or Board of Directors—from a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.) with an emphasis on primary care, such as obstetrics and pediatrics.

### Recipient

A person whom is determined eligible to receive services as provided for in the SC State Plan for Medical Assistance.

### Referral Services

Health care services provided to Medicaid Managed Care Program members outside the CONTRACTOR's designated facilities or its subcontractors when ordered and approved by the CONTRACTOR, including, but not limited to out-of-plan services which are covered under the Medicaid program and reimbursed at the Fee-For-Service Medicaid Rate.

### Relationship

Relationship is described as follows for the purposes of any business affiliations discussed in Section 5 of this Contract:

- A director, officer, or partner of the CONTRACTOR;
- A person with beneficial ownership of five (5%) percent or more of the CONTRACTOR's equity; or
- A person with an employment, consulting or other arrangement (e.g., providers) with the CONTRACTOR under its contract with the State.

### 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 is certified by the CMS and receiving Public Health Services grants. A RHC eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A RHC provides a wide range of primary care and enhanced services in a medically underserved area.

### Risk

A chance of loss assumed by the CONTRACTOR which arises if the cost of providing core benefits and covered services to Medicaid Managed Care Program members exceeds the capitation payment made by Department to the CONTRACTOR under the terms of this Contract.

### Service Area

The geographic area in which the CONTRACTOR is authorized to accept enrollment of eligible Medicaid Managed Care Members into the CONTRACTOR's plan. The service area must be approved by SCDOI.

SCDOI

South Carolina Department of Insurance.

SSA

Social Security Administration.

SSI

Supplemental Security Income.

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, and Department regulations.

South Carolina State Plan for Medical Assistance

A plan, approved by the Secretary of HHS, which complies with 42 U.S.C.A. § 1396a, and provides for the methodology of furnishing services to recipients pursuant to Title XIX.

Subcontract

A written agreement between the CONTRACTOR and a third party to perform a 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 Department under the terms of this Contract.

Subrogation

The right of the Department to stand in the place of the CONTRACTOR or client in the collection of third party resources.

Targeted Case Management (TCM)

Services that assist individuals in gaining access to needed medical, social, educational, and other services as authorized under the State Plan. Services include a systematic referral process to providers.

Termination

The Department has taken an action to revoke a provider's Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no intention on the part of the Department that the revocation is temporary.

### Third Party Resources

Any entity or funding source other than the Medicaid Managed Care Program member or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care provided to a Medicaid Managed Care Program member.

### Third Party Liability (TPL)

Collection from other parties who may be liable for all or part of the cost of items or health care services provided to a Medicaid Managed Care Program member.

### Title XIX

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

### UB-04

A uniform bill for inpatient and outpatient hospital billing. The required form is the UB-04 CMS 1500.

### Urgent Care

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

### 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.

### Value Oriented Contract (VOC)

Payment methodology(ies) designed to cut waste and/or reflect value.

- Payments that cut waste are those that, by their design, reduce unnecessary payment and unnecessary care (e.g. elective cesarean deliveries).
- Payments that reflect value are those that are tied to provider performance and may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.

### Withhold

A percentage of payments or set dollar amount that an organization deducts for a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on the specific predetermined factors.

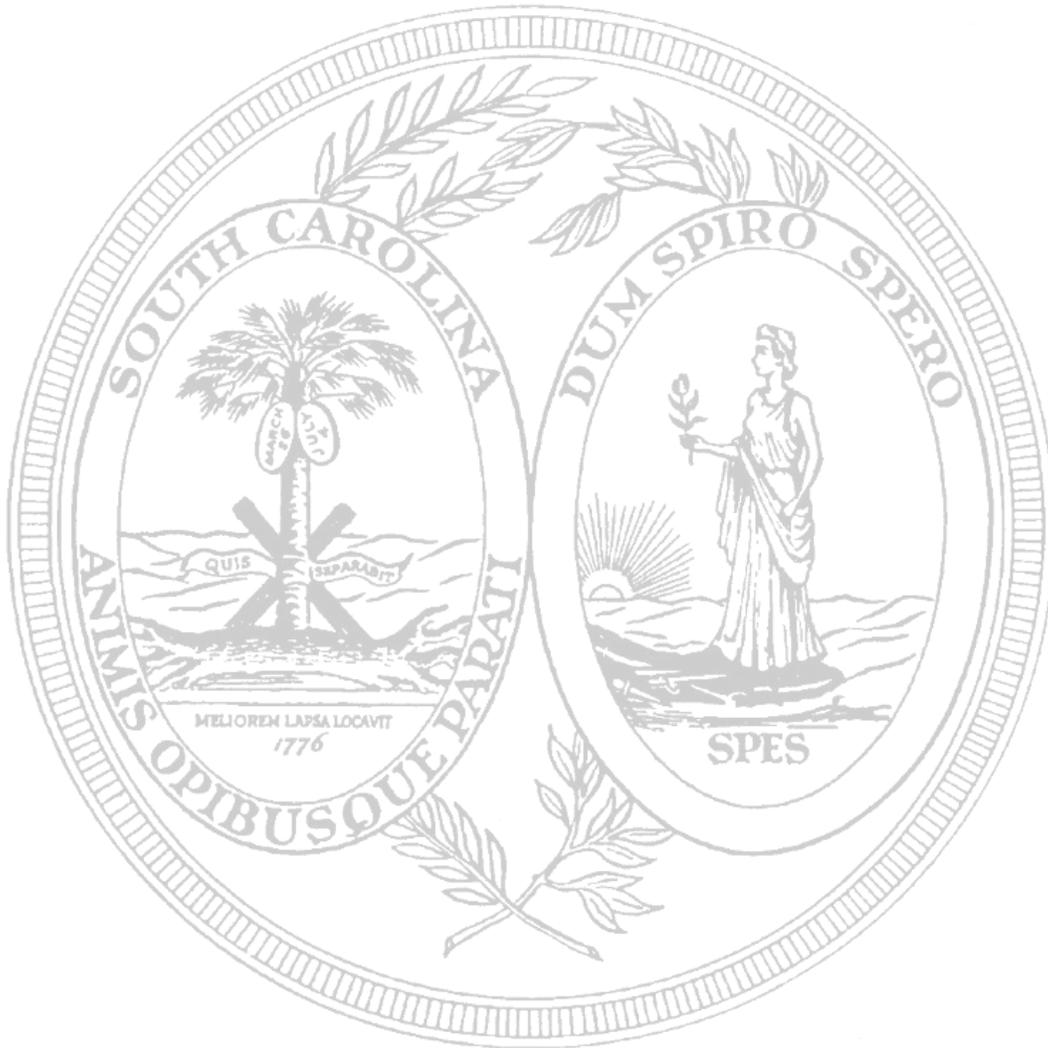


APPENDIX B.

Capitation and Reimbursement Methodology

**APPENDIX B – Capitation and Reimbursement Methodology**

INSERT HERE



APPENDIX C.

HIPPA Business Associate Terms



## APPENDIX C – HIPAA BUSINESS ASSOCIATE

### A. Purpose:

The South Carolina Department of Health and Human Services (Covered Entity) and CONTRACTOR (Business Associate) agree to the terms of this Appendix for the purpose of protecting the privacy of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in performing the functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract between the parties.

### B. Definitions:

Terms used in this Section of this Contract, but not otherwise defined, shall have the same meaning as set forth for those terms in HIPAA. A change to HIPAA which modifies any defined HIPAA term, or which alters the regulatory citation for the definition shall be deemed incorporated into this Appendix).

1. Business Associate. "Business Associate" shall mean the CONTRACTOR. Where the term "business associate" appears without an initial capital letter, it shall have the same meaning as the term "business associate" in 45 CFR § 160.103.
2. Covered Entity. "Covered Entity" shall mean SCDHHS.
3. Data Aggregation. "Data Aggregation" shall have the meaning given to the term in 45 CFR § 164.501.
4. Designated Record Set. "Designated Record Set" shall have the meaning given the term in 45 CFR § 164.501.
5. Electronic Protected Health Information and/or EPHI. "Electronic Protected Health Information" or "EPHI" shall have the meaning given the term in 45 CFR § 160.103, and shall include, without limitation, any EPHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity.
6. HIPAA. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, as amended, and related HIPAA regulations (45 CFR Parts 160-164).
7. HITECH. "HITECH" means the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

8. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).
9. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information, and Security Standards for the Protection of Electronic Protected Health Information (the "Security Rule") that are codified at 45 CFR Parts 160 and Part 164, Subparts A, C, and E and any other applicable provision of HIPAA, and any amendments thereto, including HITECH.
10. Protected Health Information or PHI. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, and shall include, without limitation, any PHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity. Unless otherwise stated in this Agreement, any provision, restriction, or obligation in this Appendix related to the use of PHI shall apply equally to EPHI.
11. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103, and any additional requirements created under HITECH.
12. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
13. Security Incident. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system as provided in 45 C.F.R. § 164.304.
14. Unsecured PHI. "Unsecured PHI" shall have the same definition that the Secretary gives the term in guidance issued pursuant to § 13402 of HITECH.

C. Business Associate Agrees to:

1. Not use or disclose PHI or EPHI other than as permitted or required by the Contract or as Required by Law.
2. Develop, implement, maintain, and use appropriate safeguards to prevent any use or disclosure of the PHI or EPHI other than as provided by this Appendix, and to implement administrative, physical, and technical safeguards as required by sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations and HITECH in order to protect the confidentiality, integrity, and availability of EPHI or PHI that Business

Associate creates, receives, maintains, or transmits, to the same extent as if Business Associate were a Covered Entity. See HITECH § 13401.

3. The additional requirements of Title XIII of HITECH that relate to privacy and security and that are made applicable with respect to covered entities shall also be applicable to Business Associate and shall be and by this reference hereby incorporated into this Appendix.
4. Adopt the technology and methodology standards provided in any guidance issued by the Secretary pursuant to HITECH § 13401-13402.
5. Mitigate to the extent practicable, any harmful effect known to Business Associate if Business Associate uses/discloses PHI in violation of the Contract or this Appendix and to notify Covered Entity of any breach of unsecured PHI, as required under HITECH § 13402.
6. Immediately report to Covered Entity any breaches in privacy or security that compromise PHI or EPHI. Security and/or privacy breaches should be reported to:

South Carolina Department of Health and Human Services  
Office of General Counsel  
Post Office Box 8206  
Columbia, South Carolina 29202-8206  
Phone: (803) 898-2795  
Fax: (803) 255-8210

The Report shall include the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during the breach. If the breach involves the Unsecured PHI of more than 500 residents of South Carolina or residents of a certain region, or is reasonably believed to have been accessed, acquired or disclosed during such incident, the Covered Entity will also notify the prominent media outlets. The media outlets must serve the geographic area affected.

SCDHHS may impose a fine of \$300 per day from the date that the Business Associate knew or should have known of any breach in privacy or security that compromises PHI to the date that SCDHHS becomes aware of the breach.

SCDHHS may impose a fine of up to \$25,000 for any negligent breach in privacy or security that compromises PHI.

7. Ensure that any agent/subcontractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Appendix. Business Associate must obtain, prior to making any permitted disclosure to any agent/subcontractor, reasonable assurances from such third party that such PHI will be held secure and confidential as provided pursuant to this Appendix and only disclosed as required by law or for the

purposes for which it was disclosed to such third party, and that any breaches of confidentiality of the PHI which become known to such third party will be immediately reported to Business Associate. As part of obtaining this reasonable assurance, Business Associate agrees to enter into a Business Associate Agreement with each of its subcontractors pursuant to 45 CFR § 164.308(b)(1) and HITECH § 13401.

8. If the Business Associate has PHI in a Designated Record, provide access at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.
9. If the Business Associate has PHI in a Designated Record Set, make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.
10. Make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
11. Document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
12. Provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with Section C.8 of this Appendix, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
13. Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberry's, cell phones, portable audio/video devices (such as iPods and MP3 and MP4 players), and personal organizers. Portable devices that perform computing, data manipulation or data transmission are called intelligent portable devices.

14. Business Associate understands and agrees that, should SCDHHS be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this Section, Business Associate shall be liable to SCDHHS for any damages, penalties and/or fines assessed against SCDHHS as a result of Business Associate's material breach. SCDHHS is authorized to recoup any and all such damages, penalties and/or fines assessed against SCDHHS by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which SCDHHS may be obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and SCDHHS, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

D. Permitted Uses and Disclosures by Business Associate

1. Except as limited in this Appendix, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract noted in A. provided that such use would not violate the Privacy Rule if done by Covered Entity or the Covered Entity's minimum necessary policies and procedures. Unless otherwise permitted in this Appendix, in the Contract noted in A. above or as required by Law, Business Associate may not disclose or re-disclose PHI except to Covered Entity.
2. Except as limited in this Appendix, Business Associate may use or disclose PHI for the proper internal management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide services to Covered Entity under the above noted Contract.
3. Except as limited in this Appendix, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).
4. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

E. Covered Entity Shall:

1. Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

2. Notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
3. Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.
4. Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

F. Term and Termination

1. The terms of this Appendix shall be effective immediately upon award of the Contract noted in A. and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.
2. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall:
  - a. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; OR
  - b. Immediately terminate the Contract if Business Associate has breached a material term of this Appendix and cure is not possible; OR
  - c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.
3. Effect of Termination.
  - a. Except as provided in paragraph (2) below, upon termination of the Contract, for any reason, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision applies to PHI in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
  - b. In the event that Business Associate determines that returning the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is

infeasible, Business Associate shall extend the protections of this Appendix to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

G. Security Compliance

This Section shall be effective on the applicable enforcement date of the Security Standards. Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity, and will require that its agents and subcontractors to whom it provides such information do the same. Further, Business Associate agrees to comply with Covered Entity's security policies and procedures. Business Associate also agrees to provide Covered Entity with access to and information concerning Business Associate's security and confidentiality policies, processes, and practices that affect Electronic PHI provided to or created by Business Associate pursuant to the Agreement upon reasonable request of the Covered Entity. Covered Entity shall determine if Business Associate's security and confidentiality practices, policies, and processes comply with HIPAA, as amended from time to time, and all regulations promulgated under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

H. Miscellaneous

1. A reference in this Appendix to a section in the Privacy Rule means the section as in effect or as amended.
2. The Parties agree to amend this Appendix as necessary to comply with HIPAA and other applicable law.
3. Any provision related to the use, disclosure, access, or protection of EPHI or PHI or that by its terms should survive termination of this Agreement shall survive termination.
4. Any ambiguity in this Appendix shall be resolved to permit Covered Entity to comply with the Privacy Rule.



APPENDIX D.  
Subcontract Boilerplate Requirements

## APPENDIX D — SUBCONTRACT BOILERPLATE REQUIREMENTS

The provisions in this Section shall be primary and supersede any provision to the contrary which may occur in any other section of this subcontract.

### A. Definitions:

1. Action – As related to Grievance, either (1) the denial or limited authorization of a requested service, including the type or level of service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by SCDHHS; (5) the failure of the MCO to act within the timeframes provided in the MCO Contract; or (6) for a resident of a rural area with only one MCO, the denial of a Medicaid MCO Member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the MCO's network.
2. Additional Service(s) – A service(s) provided by the MCO that is a non-covered service(s) by the South Carolina State Plan for Medical Assistance and is offered to Medicaid MCO Members in accordance with the standards and other requirements set forth in the MCO Contract, which are outlined in another section of this Contract.
3. Clean Claim – A claim that can be processed without obtaining additional information from the Provider of the service or from a third party.
4. Continuity of Care – The continuous treatment for a condition (such as pregnancy) or duration of illness from the time of first contact with a healthcare provider through the point of release or long-term maintenance.
5. 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 and/or her unborn child) in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
6. 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.
7. Federal Qualified Health Center (FQHC) – A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants. An FQHC provides a wide range of primary care and enhanced services in a medically under-served area.
8. Grievance – An expression of dissatisfaction about any matter other than an Action. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO level. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a

provider or employee, or failure to respect the Medicaid MCO Member's rights.)

9. Healthcare Medicaid Provider – A provider of healthcare services or products which includes but is not limited to an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, group or association approved by SCDHHS, licensed and/or credentialed which accepts as payment in full for providing benefits to Medicaid MCO Members amounts pursuant to the MCO reimbursement provisions, business requirements and schedules.
10. 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 42 CFR Part 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 MCO Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area serviced by the entity; and (b) meets the solvency standards of 42 CFR §438.116. This includes any of the entity's employees, affiliated providers, agents, or CONTRACTORS.
11. 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 MCO Member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of the Medicaid MCO Member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.
12. Medicaid MCO Member – An eligible person(s) who is enrolled with a SCDHHS approved Medicaid Managed Care Organization. For purpose of this subcontract, Medicaid MCO Member shall include the patient, parent(s), guardian, spouse or any other person legally responsible for the Medicaid MCO Member being served.
13. MCO - The Managed Care Organization who is requesting services under this Contract.
14. Primary Care Provider (PCP) – The provider who serves as the entry point into the health care system for the Medicaid MCO Member. The PCP is responsible for providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining Continuity of Care.
15. Rural Health Clinic (RHC) – A South Carolina licensed rural health clinic is certified by the Centers for Medicare and Medicaid Services and receiving 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.
16. Provider – The Healthcare Medicaid Provider who is providing services for the MCO under this Contract.

## **B. Administration**

1. SCDHHS retains the right to review any and all subcontracts entered into for the provision of any services under this Contract.
2. SCDHHS does not require Provider to participate in any other line of business (i.e. Medicare Advantage or commercial) offered by the MCO in order to participate in the MCO's Medicaid network.
3. SCDHHS does not require Provider to participate in the network of any other Managed Care Organization as a condition of participation in MCO's network.
4. MCO and Provider shall be responsible for resolving any disputes that may arise between the two (2) parties, and no dispute shall disrupt or interfere with the Continuity of Care of a Medicaid MCO Member.
5. Provider represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Provider further covenants that, in the performance of this Contract, no person having any such known interests shall be employed.
6. Provider recognizes that in the event of termination of the MCO Contract between MCO and SCDHHS, the MCO is required to make available to SCDHHS or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and Provider's activities undertaken pursuant to this Contract. The Provider agrees to furnish any records to the MCO that the MCO would need in order to comply with this provision. The provision of such records shall be at no expense to SCDHHS.
7. In the event of termination of this Contract, SCDHHS will be notified of the intent to terminate this Contract one hundred and twenty (120) calendar days prior to the effective date of termination. The date of termination will be at midnight on the last day of the month of termination.
8. If the termination of this Contract is as a result of a condition or situation which would have an adverse impact on the health and safety of Medicaid MCO Members, the termination shall be effective immediately and SCDHHS will be immediately notified of the termination and provided any information requested by SCDHHS.

**C. Hold Harmless**

1. At all times during the term of this Contract, Provider shall, except as otherwise prohibited or limited by law, indemnify and hold SCDHHS harmless from all claims, losses, or suits relating to activities undertaken pursuant to this Contract.
2. If Provider is not a political subdivision of the State of South Carolina, an affiliate organization, or otherwise prohibited or limited by law, Provider shall indemnify, defend, protect, and hold harmless SCDHHS and any of its officers, agents, and employees from:
  - a. Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the Provider in connection with the performance of this Contract;
  - b. Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or

federal Medicaid regulations or legal statutes, by Provider, its agents, officers, employees, or subcontractors in the performance of this Contract;

- c. Any claims for damages or losses resulting to any person or firm injured or damaged by Provider, its agents, officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by federal or state regulations or statutes;
  - d. Any failure of the Provider, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
  - e. Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of SCDHHS in connection with the defense of claims for such injuries, losses, claims, or damages specified above;
  - f. Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against SCDHHS or their agents, officers or employees, through the intentional conduct, negligence or omission of the Provider, its agents, officers, employees or subcontractors.
3. As required by the South Carolina Attorney General, in circumstances where the Provider is a political subdivision of the State of South Carolina, or an affiliate organization, except as otherwise prohibited by law, neither Provider nor SCDHHS shall be liable for any claims, demands, expenses, liabilities and losses (including reasonable attorney's fees) which may arise out of any acts or failures to act by the other party, its employees or agents, in connection with the performance of services pursuant to this Contract.
  4. In accordance with the requirements of S.C. Code Ann. § 38-33-130(b) (Supp. 2001, as amended), and as a condition of participation as a Healthcare Medicaid Provider, Provider hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Medicaid MCO Members, or persons acting on their behalf, for health care services which are rendered to such Medicaid MCO Members by the Provider, and which are covered benefits under the Medicaid MCO Member's evidence of coverage. This provision applies to all covered health care services furnished to the Medicaid MCO Member for which SCDHHS does not pay the MCO or the MCO does not pay the Provider. Provider agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by MCO and insolvency of MCO. Provider further agrees that this provision shall be construed to be for the benefit of Medicaid MCO Members and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and such Medicaid MCO Members.
  5. It is expressly agreed that the MCO, Provider and agents, officers, and employees of the MCO or Provider in the performance of this Contract shall act in an independent capacity and not as officers and employees of SCDHHS or

the State of South Carolina. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the MCO or Provider and SCDHHS and the State of South Carolina.

**D. Health Care Services**

1. Provider shall ensure adequate access to the services provided under this Contract in accordance with the prevailing medical community standards.
2. The services covered by this Contract must be in accordance with the South Carolina State Plan for Medical Assistance under Title XIX of the Social Security Act, and Provider shall provide these services to Medicaid MCO Members through the last day that this Contract is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of SCDHHS or its designee.
3. Provider may not refuse to provide Medically Necessary Services or covered preventive services to Medicaid MCO Members for non-medical reasons.
4. Provider shall render Emergency Services without the requirement of prior authorization of any kind.
5. The Provider shall not be prohibited or otherwise restricted from advising a Medicaid MCO Member about the health status of the Medicaid MCO Member or medical care or treatment for the Medicaid MCO Member's condition or disease, regardless of whether benefits for such care or treatment are provided under the MCO Contract, if Provider is acting within the lawful scope of practice.
6. Provider must take adequate steps to ensure that Medicaid MCO Members with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended).
7. Provider shall provide effective Continuity of Care activities, if applicable, that seek to ensure that the appropriate personnel, including the Primary Care Provider (PCP), are kept informed of the Medicaid MCO Member's treatment needs, changes, progress or problems
8. Provider must adhere to the Quality Assessment Performance Improvement and Utilization Management (UM) requirements as outlined by SCDHHS and/or its designee.
9. Provider shall have an appointment system for Medically Necessary Services that is in accordance with prevailing medical community standards.
10. Provider shall not use discriminatory practices with regard to Medicaid MCO Members such as separate waiting rooms, separate appointment days, or preference to private pay patients.
11. Provider must identify Medicaid MCO Members in a manner that will not result in discrimination against the Medicaid MCO Member in order to provide or coordinate the provision of all core benefits and/or Additional Services and out of plan services.

12. Provider agrees that no person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of the MCO's program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of Provider. Provider shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.
13. If the Provider performs laboratory services, the Provider must meet all applicable state and federal requirements related thereto.
14. If Provider is a hospital, Provider shall notify the MCO and SCDHHS of the births when the mother is a Medicaid MCO Member. Provider shall also complete SCDHHS Request for Medicaid ID Number (Form 1716 ME), including indicating whether the mother is a Medicaid MCO Member, and submit the form to the local/state SCDHHS office.
15. If Provider is an FQHC/RHC, Provider shall adhere to federal requirements for reimbursement for FQHC/RHC services. This Contract shall specify the agreed upon payment from the MCO to the FQHC/RHC. Any bonus or incentive arrangements made to the FQHCs/RHCs associated with Medicaid MCO Members must also be specified and included this Contract.
16. If Provider is a PCP, then Provider shall have an appointment system for covered core benefits and/or Additional Services that is in accordance with prevailing medical community standards but shall not exceed the following requirements:
  - a. Routine visits scheduled within four (4) weeks.
  - b. Urgent, non-emergency visits within forty-eight (48) hours.
  - c. Emergent or emergency visits immediately upon presentation at a service delivery site.
  - d. Waiting times that do not exceed forty-five (45) minutes for a scheduled appointment of a routine nature.
  - e. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.
  - f. Walk-in patients with urgent needs should be seen within forty-eight (48) hours.
17. As a PCP, Provider must also provide twenty-four (24) hour coverage but may elect to provide twenty-four (24) hour coverage by direct access or through arrangement with a triage system. The triage system arrangement must be prior approved by MCO.
18. Provider shall submit all reports and clinical information required by the MCO, including Early Periodic Screening, Diagnosis, and Treatment (if applicable).

#### **E. Laws**

1. Provider shall recognize and abide by all state and federal laws, regulations and SCDHHS guidelines applicable to the provision of services under the Medicaid MCO Program.

2. Provider must comply with all applicable statutory and regulatory requirements of the Medicaid program and be eligible to participate in the Medicaid program.
3. This Contract shall be subject to and hereby incorporates by reference all applicable federal and state laws, regulations, policies, and revisions of such laws or regulations shall automatically be incorporated into the Contract as they become effective.
4. Provider represents and warrants that it has not been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or is not otherwise barred from participation in the Medicaid and/or Medicare program.
5. Provider also represents and warrants that it has not been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.
6. Provider shall not have a Medicaid contract with SCDHHS that was terminated, suspended, denied, or not renewed as a result of any action of Center for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services (HHS), or the Medicaid Fraud Unit of the Office of the South Carolina Attorney General. Providers who have been sanctioned by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and are currently under suspension shall not be allowed to participate in the Medicaid MCO Program. In the event Provider is suspended, sanctioned or otherwise excluded during the term of this Contract, Provider shall immediately notify MCO in writing.
7. Provider ensures that it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other Contract with debarred individuals for the provision of items and services that are significant to the MCO's contractual obligation.
8. Provider shall check the Excluded Parties List Service administered by the General Services Administration, when it hires any employee or contracts with any subcontractor, to ensure that it does not employ individuals or use subcontractors who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other contract with debarred individuals for the provision of items and services that are significant to Provider's contractual obligation. Provider shall also report to the MCO any employees or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.
9. In accordance with 42 CFR §455.104 (2010, as amended), the Provider agrees to provide full and complete ownership and disclosure information with the execution of this Contract and to report any ownership changes within thirty-five (35) calendar days to MCO. Provider must download the appropriate form from the MCO website or request a printed copy be sent. Failure by the Provider to disclose this information may result in termination of this Contract.

10. It is mutually understood and agreed this Section of the Contract shall be governed by the laws and regulations of the State of South Carolina both as to interpretation and performance by Provider. Any action at law, suit in equity, or judicial proceeding for the enforcement of this Section of the Contract or any provision thereof shall be instituted only in the courts of the State of South Carolina. Specific provisions related to dispute resolution between the MCO and Provider related to the other sections of this Contract are provided in those other sections.

**F. Billing a Medicaid MCO Member**

Provider may only bill a Medicaid MCO Member under the following conditions:

1. When Provider renders services that are non-covered services and are not Additional Services, as long as the Provider:
  - a. Provides to the Medicaid MCO Member a written statement of the services prior to rendering said services, which must include:
    - i. The cost of each service(s)
    - ii. An acknowledgement of Medicaid MCO Member's payment responsibility, and
    - iii. Obtains Medicaid MCO Member's signature on the statement.
2. When the service provided has a co-payment, as allowed by the MCO, Provider may charge the Medicaid MCO Member only the amount of the allowed co-payment, which cannot exceed the co-payment amount allowed by SCDHHS.

**G. Audit, Records and Oversight**

1. Provider shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly accepted information elements for services rendered to Medicaid MCO Members pursuant to this Contract (including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed). Medicaid MCO Members and their representatives shall be given access to and can request copies of the Medicaid MCO Members' medical records, to the extent and in the manner provided by S.C. Code Ann. §44-115-10 et. seq., (Supp. 2000, as amended).
2. SCDHHS, HHS, CMS, the Office of Inspector General, the State Comptroller, the State Auditor's Office, and the South Carolina Attorney General's Office shall have the right to evaluate, through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Contract, including those pertaining to quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Provider claims submitted to the MCO. The Provider shall cooperate with these evaluations and inspections. Provider will make office work space available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provision of services under this Contract.
3. Whether announced or unannounced, Provider shall participate and cooperate in any internal and external quality assessment review, utilization management, and Grievance procedures established by SCDHHS or its designee.

4. Provider shall comply with any plan of correction initiated by the MCO and/or required by SCDHHS.
5. All records originated or prepared in connection with the Provider's performance of its obligations under this Contract, including, but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the Provider in accordance with the terms and conditions of this Contract. The Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Medicaid MCO Members relating to the delivery of care or service under this Contract, and as further required by SCDHHS, for a period of five (5) years from the expiration date of the Contract, including any Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five (5) year period, whichever is later. If Provider stores records on microfilm or microfiche, Provider must produce, at its expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request.
6. SCDHHS and/or any designee will also have the right to:
  - a. Inspect and evaluate the qualifications and certification or licensure of Provider;
  - b. Evaluate, through inspection of Provider's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to Medicaid MCO Members;
  - c. Audit and inspect any of Provider's records that pertain to health care or other services performed under this Contract, determine amounts payable under this Contract;
  - d. Audit and verify the sources of encounter data and any other information furnished by Provider or MCO in response to reporting requirements of this Contract or the MCO Contract, including data and information furnished by subcontractors.
7. Provider shall release medical records of Medicaid MCO Members, as may be authorized by the Medicaid MCO Member or as may be directed by authorized personnel of SCDHHS, appropriate agencies of the State of South Carolina, or the United States Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Contract.
8. Provider shall maintain up-to-date medical records at the site where medical services are provided for each Medicaid MCO Member for whom services are provided under this Contract. Each Medicaid MCO Member's record must be legible and maintained in detail consistent with good medical and professional practice, which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. SCDHHS representatives or designees shall have immediate and complete access to all records pertaining to the health care services provided to the Medicaid MCO Member.

## **H. Safeguarding Information**

1. Provider shall safeguard information about Medicaid MCO Members according to applicable state and federal laws and regulations.
2. Provider shall assure that all material and information, in particular information relating to Medicaid MCO Members, which is provided to or obtained by or through the Provider's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be protected as confidential information to the extent confidential treatment is protected under state and federal laws. Provider shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.
3. All information as to personal facts and circumstances concerning Medicaid MCO Members obtained by the Provider shall be treated as privileged communications, shall be held confidential, and shall not be divulged to third parties without the written consent of SCDHHS or the Medicaid MCO Member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Medicaid MCO Members shall be limited to purposes directly connected with the administration of this Contract.
4. All records originated or prepared in connection with Provider's performance of its obligations under this Contract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the Provider and its subcontractors in accordance with the terms and conditions of this Contract.

## **I. Payment Timeframes**

1. The MCO shall pay ninety percent (90%) of all Clean Claims from practitioners, either in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt. The MCO shall pay ninety-nine percent (99%) of all Clean Claims from practitioners, either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt. The date of receipt is the date the MCO receives the claim, as indicated by its data stamp on the claim. The date of payment is the date of the check or other form of payment.
2. The MCO and Provider may, by mutual agreement, establish an alternative payment schedule to the one presented.
3. Provider shall accept payment made by the MCO as payment-in-full for covered services and Additional Services provided and shall not solicit or accept any surety or guarantee of payment from the Medicaid MCO Member, except a specifically allowed by Subsection F, Member Billing, of this Section.
4. This Contract shall not contain any provision that provides incentives, monetary or otherwise, for the withholding of Medically Necessary Services.

5. Any incentive plans for providers shall be in compliance with 42 CFR Part 434 (2009, as amended), 42 CFR § 417.479 (2008, as amended), 42 CFR §422.208 and 42 CFR §422.210 (2008, as amended).

