

SOUTH CAROLINA

Healthy Connections
MEDICAID



**POLICY and PROCEDURE GUIDE
For
MANAGED CARE ORGANIZATIONS**

July 1, 2014

INTRODUCTION..... 1

REQUIREMENTS FOR CERTIFICATION AS A MCO 2

THE CONTRACT PROCESS 2

 1.0 GENERAL PROVISIONS..... 4

 2.0 CONTRACTOR ADMINISTRATIVE REQUIREMENTS 4

 2.1 DELEGATION OF AUTHORITY 4

 2.2 CONTRACTOR ADMINISTRATION AND MANAGEMENT..... 4

 2.3 CREDENTIALING 5

 2.4 SUBCONTRACTOR REQUIREMENTS 5

 2.5 IMMUNIZATION DATA AND FEDERAL FUNDS RESTRICTIONS..... 7

 2.6 PROVIDER ENROLLMENT..... 7

 3.0 ELIGIBILITY AND ENROLLMENT 7

 3.1 ENROLLMENT 7

 3.2 ENROLLMENT PROCESS..... 9

 3.3 DISENROLLMENT PROCESS 13

 3.4 NOTIFICATION TO MCO OF MEMBERSHIP 16

 3.5 MAXIMUM ENROLLMENT..... 16

 3.6 SUSPENSION AND/OR DISCONTINUATION OF ENROLLMENT..... 16

 3.7 REDETERMINATION NOTICE 16

 3.8 MEMBER CALL CENTER 17

 3.9 MEMBER HANDBOOK..... 17

 3.10 PROVIDER DIRECTORY..... 18

 3.11 BILLING AND RECONCILIATION..... 18

 3.12 MEMBER EDUCATION..... 19

 3.13 MEMBER COMMUNICATION..... 19

 3.14 ENROLLMENT AND DISENROLLMENT PROCESS 20

 4.0 SERVICES 20

 4.1 CORE BENEFITS FOR THE SOUTH CAROLINA MEDICAID MCO PROGRAM..... 20

 4.2 SERVICE LIMITS..... 41

 4.3 OUT OF NETWORK COVERAGE 41

 4.4 SECOND OPINIONS 41

 4.5 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)/WELL CHILD VISITS . 41

 4.6 EMERGENCY MEDICAL SERVICES 41

Managed Care Organizations Policy and Procedure Guide

4.7 PHARMACY / PRESCRIPTION DRUGS 41

4.8 HYSTERECTOMIES 42

4.9 STERILIZATION 42

4.10 LIMITATIONS OF ABORTIONS 42

4.11 MEDICAL SERVICES FOR SPECIAL POPULATIONS 42

4.12 TARGETED CASE MANAGEMENT (TCM) SERVICES 42

4.13 SCHOOL-BASED SERVICES 42

4.14 INSTITUTIONAL LONG-TERM CARE (LTC) FACILITIES/ NURSING FACILITIES (NFs) 43

4.15 BEHAVIORAL HEALTH SERVICES 43

4.16 COMMUNICABLE DISEASE SERVICES..... 43

4.17 MEMBER INCENTIVES..... 43

4.18 ADDITIONAL SERVICES 44

4.19 EXCLUDED SERVICES 45

4.20 MEDICAL NECESSITY DETERMINATION 49

4.21 MORAL AND RELIGIOUS OBJECTION 49

5.0 CARE COORDINATION 49

5.1 CARE MANAGEMENT 50

5.2 TRANSITION OF CARE 50

5.3 CONTINUITY OF CARE 51

5.4 COORDINATION OF REFERRAL(S) OUTSIDE OF CORE BENEFITS 51

5.5 HEALTH HOMES AND CARE COORDINATION..... 51

6.0 NETWORKS (PROVIDER NETWORK REQUIREMENTS)..... 52

6.1 GENERAL REQUIREMENTS (PROVIDER NETWORK ADEQUACY DETERMINATION PROCESS)..... 52

6.2 PROVIDER NETWORK..... 58

NETWORK TERMINATION / TRANSITION PROCESS..... 61

6.3 ATTESTATIONS..... 64

6.4 REGIONAL PROVIDER NETWORKS..... 64

7.0 PAYMENTS 64

7.1 FINANCIAL MANAGEMENT 64

7.2 CAPITATION PAYMENTS FROM THE DEPARTMENT TO CONTRACTOR 64

7.3 PAYMENTS FROM CONTRACTOR TO SUBCONTRACTOR..... 72

7.4 PAYMENT STANDARDS..... 74

7.5 PROHIBITED PAYMENTS 74

Managed Care Organizations Policy and Procedure Guide

7.6 RETURN OF FUNDS 74

8.0 UTILIZATION MANAGEMENT 74

8.1 MANAGEMENT 74

8.2 CONTRACTOR UTILIZATION MANAGEMENT (UM) PROGRAM REQUIREMENTS..... 74

8.3 PRACTICE GUIDELINES 74

8.4 SERVICE AUTHORIZATION 74

8.5 TIMEFRAME OF SERVICE AUTHORIZATION DECISIONS 75

8.6 STANDARD SERVICE AUTHORIZATION 75

8.7 EXPEDITED SERVICE AUTHORIZATION 75

8.8 EXCEPTIONS TO SERVICE AUTHORIZATION REQUIREMENTS 75

8.9 OUT-OF-NETWORK USE OF NON-EMERGENCY SERVICES 75

9.0 GRIEVANCE AND APPEALS PROCEDURES..... 75

9.1 MEMBER GRIEVANCE AND APPEAL 75

9.2 PROVIDER DISPUTE SYSTEM 77

10.0 THIRD PARTY LIABILITY 78

10.1 GENERAL..... 78

10.2 DEPARTMENTAL RESPONSIBILITIES..... 78

10.3 CONTRACTOR RESPONSIBILITIES 79

10.4 COST AVOIDANCE 79

10.5 POST PAYMENT RECOVERIES (BENEFIT RECOVERY ACTIVITIES) 80

10.6 RETROACTIVE ELIGIBILITY FOR MEDICARE 82

10.7 THIRD PARTY LIABILITY REPORTING DISENROLLMENT REQUESTS..... 82

10.8 THIRD PARTY LIABILITY RECOVERIES BY THE DEPARTMENT 82

10.9 REPORTING REQUIREMENTS..... 83

11.0 PROGRAM INTEGRITY..... 84

11.1 GENERAL (CONTRACTOR PROGRAM INTEGRITY AND COMPLIANCE PROGRAMS)..... 84

11.2 CONTRACTOR REQUIREMENTS..... 84

11.3 CONTRACTOR SUBCONTRACTING REVIEW AND APPROVAL PROCEDURES..... 84

11.4 PROVIDER REVIEW, INVESTIGATION, AND FRAUD/ABUSE REPORTING REQUIREMENTS..... 84

11.5 RECOVERIES AND PROVIDER REFUNDS 90

11.6 REPORTING REQUIREMENTS FOR PROGRAM INTEGRITY..... 93

11.7 OWNERSHIP AND CONTROL..... 96

11.8 CONTRACTOR PROVIDERS AND EMPLOYEES – EXCLUSIONS, DEBARMENT, AND 96

Managed Care Organizations Policy and Procedure Guide

11.9	PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.....	97
11.10	PROVIDER TERMINATION/DENIAL OF CREDENTIALS.....	97
11.11	INFORMATION RELATED TO BUSINESS TRANSACTIONS	97
11.12	INFORMATION ON PERSONS CONVICTED OF CRIMES.....	97
12.0	MARKETING PROGRAM	98
12.1	GENERAL MARKETING REQUIREMENTS	98
12.2	PRIOR APPROVAL OF MARKETING MATERIALS	99
12.3	GUIDELINES FOR MARKETING MATERIALS AND ACTIVITIES	99
13.0	REPORTING REQUIREMENTS.....	105
13.1	GENERAL REQUIREMENTS	105
13.2	REPORTING REQUIREMENTS.....	106
14.0	ENCOUNTER DATA, REPORTING AND SUBMISSION REQUIREMENTS	106
14.1	GENERAL DATA REQUIREMENTS	106
14.2	ENCOUNTER DATA	106
14.3	ERRORS AND ENCOUNTER VALIDATION.....	108
14.4	SYSTEM AND INFORMATION SECURITY ACCESS MANAGEMENT REQUIREMENTS	110
15.0	QUALITY ASSESSMENT, MONITORING, AND REPORTING.....	111
15.1	QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI).....	111
15.2	PERFORMANCE IMPROVEMENT PROJECTS (PIP).....	111
15.3	MEMBER SATISFACTION SURVEY.....	111
15.4	QUALITY PERFORMANCE MEASURES	111
15.5	MINIMUM PERFORMANCE FOR WITHHOLD MEASURES	111
15.6	QUALITY WITHHOLD AND BONUS PROGRAMS	111
15.7	VALUE ORIENTED CONTRACTING (VOC).....	124
15.8	NCQA ACCREDITATION.....	127
15.9	EXTERNAL QUALITY REVIEW (EQR)	127
15.10	PROVIDER PREVENTABLE CONDITIONS	130
16.0	DEPARTMENT’S RESPONSIBILITIES	131
16.1	DEPARTMENT CONTRACT MANAGEMENT.....	131
16.2	PAYMENT OF CAPITATED RATE	131
16.3	NOTIFICATION OF MEDICAID MCO PROGRAM POLICIES AND PROCEDURES.....	131
16.4	QUALITY ASSESSMENT AND MONITORING ACTIVITIES.....	131
16.5	FEE-FOR-SERVICE (FFS) REPORTING TO MCOs	131

Managed Care Organizations Policy and Procedure Guide

16.6 REQUEST FOR PLAN OF CORRECTION 131

16.7 EXTERNAL QUALITY REVIEW 131

16.8 MARKETING 132

16.9 GRIEVANCES/APPEALS..... 132

16.10 TRAINING..... 132

17.0 TERMINATION AND AMENDMENTS 132

17.1 TERMINATION..... 132

17.2 TERMINATION UNDER MUTUAL AGREEMENT 132

17.3 TERMINATION BY DEPARTMENT FOR BREACH 132

17.4 TERMINATION FOR UNAVAILABILITY OF FUNDS..... 133

17.5 TERMINATION FOR CONTRACTOR INSOLVENCY, BANKRUPTCY, INSTABILITY OF FUNDS..... 133

17.6 TERMINATION BY THE CONTRACTOR..... 133

17.7 TERMINATION FOR LOSS OF LICENSURE OR CERTIFICATION..... 133

17.8 TERMINATION FOR NONCOMPLIANCE WITH THE DRUG FREE WORKPLACE ACT..... 133

17.9 TERMINATION FOR ACTIONS OF OWNERS/MANAGERS 133

17.10 NON-RENEWAL 133

17.11 TERMINATION PROCESS..... 133

17.12 AMENDMENTS AND RATE ADJUSTMENTS..... 133

18.0 AUDITS, FINES AND LIQUIDATED DAMAGES 134

18.1 AUDIT..... 134

18.2 LIQUIDATED DAMAGES FOR FAILURE TO MEET CONTRACT REQUIREMENTS 134

18.3 CORRECTIVE ACTION PLAN..... 134

18.4 SANCTIONS..... 134

18.5 PLAN OF CORRECTION REQUIRED (CONTRACT NON-COMPLIANCE)..... 138

19.0 TERMS AND CONDITIONS..... 138

19.1 GENERAL CONTRACTUAL CONDITION 138

19.2 HIPAA COMPLIANCE..... 138

19.3 SAFEGUARDING INFORMATION..... 138

19.4 HIPAA BUSINESS ASSOCIATE 139

19.5 RELEASE OF RECORDS..... 139

19.6 CONFIDENTIALITY OF INFORMATION 139

19.7 INTEGRATION 139

19.8 HOLD HARMLESS 139

Managed Care Organizations Policy and Procedure Guide

19.9 HOLD HARMLESS AS TO THE MEDICAID MANAGED CARE PROGRAM MEMBERS 139

19.10 NOTIFICATION OF LEGAL ACTION..... 139

19.11 NON-DISCRIMINATION 139

19.12 SAFETY PRECAUTIONS 140

19.13 LOSS OF FEDERAL FINANCIAL PARTICIPATION 140

19.14 SHARING OF INFORMATION..... 140

19.15 APPLICABLE LAWS AND REGULATIONS 140

19.16 INDEPENDENT CONTRACTOR 140

19.17 GOVERNING LAW AND PLACE OF SUIT 140

19.18 SEVERABILITY 140

19.19 COPYRIGHTS..... 140

19.20 SUBSEQUENT CONDITIONS 140

19.21 INCORPORATION OF SCHEDULES/APPENDICES 141

19.22 TITLES..... 141

19.23 POLITICAL ACTIVITY 141

19.24 FORCE MAJEURE 141

19.25 CONFLICT OF INTEREST 141

19.26 DEPARTMENT POLICIES AND PROCEDURES 141

19.27 STATE AND FEDERAL LAW 141

19.28 CONTRACTOR’S APPEAL RIGHTS..... 141

19.29 COLLUSION/ANTI-TRUST..... 141

19.30 INSPECTION OF RECORDS 142

19.31 NON-WAIVER OF BREACH..... 142

19.32 NON-ASSIGNABILITY..... 142

19.33 LEGAL SERVICES 142

19.34 ATTORNEY’S FEES 142

19.35 RETENTION OF RECORDS..... 142

DEFINITION OF TERMS 143

APPENDIX 1 — MEMBERS’ AND POTENTIAL MEMBERS’ BILL OF RIGHTS 153

APPENDIX 2 — PROVIDERS’ BILL OF RIGHTS..... 155

**APPENDIX 3 — TRANSPORTATION BROKER LISTING AND CONTACT
INFORMATION 156**

MANAGED CARE ORGANIZATION PROGRAMS

The purpose of this guide is to document the medical and Program Policies and requirements implemented by the SCDHHS for Managed Care Organizations (MCO) wishing to conduct business in South Carolina. In the event of any confusion or disagreement as to the meaning or intent of the requirements of the Policies and Procedures contained herein, SCDHHS shall have the ultimate authority to interpret said requirements, of the Policies and Procedures, and the SCDHHS' interpretation shall control.

INTRODUCTION

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency in South Carolina responsible for the administration of a program of medical assistance under Title XIX of the Social Security Act known as the Medicaid Program. The United States Department of Health and Human Services (USDHHS) allocated funds under Title XIX to the SCDHHS for the provision of medical services for Eligible persons in accordance with the South Carolina State Plan for Medical Assistance.

SCDHHS has defined its mission as providing statewide leadership to most effectively utilize resources to promote the health and well-being of South Carolinians. The State intends to promote and further its mission by defining measurable results that will improve Medicaid MCO Member access and satisfaction, maximize Program efficiency, effectiveness, and responsiveness, and reduce operational and service costs. The following methods are intended to support the achievement of this mission:

- Provide a medical home for Medicaid Beneficiaries to promote Continuity of Care
- Emphasize prevention and self-management to improve Quality of life
- Supply Providers and Medicaid MCO Members with evidence-based information and resources to support optimal health management
- Utilize data management and feedback to improve health outcomes for the state

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

- Accessible, comprehensive, family centered, coordinated care
- A medical home with a Provider to manage the patient's health care, to perform primary and preventive care services and to arrange for any additional needed care
- Patient access to a "live voice" 24 hours a day, 7 days a week, to ensure access to appropriate care

- Patient education regarding preventive and primary health care, utilization of the medical home and appropriate use of the emergency room

The Office of Health Programs is responsible for the formulation of medical and program policy, interpretation of these policies and oversight of quality and utilization management requirements set forth in this guide. MCOs in need of assistance to locate, clarify, or interpret medical or program policy should contact the Office of Health Programs at the following address:

Office of Health Programs
Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206
Fax: (803) 255-8232
Telephone: (803) 898-4614

Requests to add, modify, or delete standards, criteria, or requirements related to current medical or program policy should be forwarded to the Office of Health Programs.

REQUIREMENTS FOR CERTIFICATION AS A MCO

THE CONTRACT PROCESS

SCDHHS will furnish potential MCOs with a copy of the model MCO contract upon request. This contract may also be found on the SCDHHS Web site at www.scdhhs.gov. The model contract has been approved by the Centers for Medicare and Medicaid Services (CMS). The terms of the contract are established and are not negotiable.

SCDHHS will enter into a risk-based contract with a qualified MCO to operate as a domestic insurer in the state of South Carolina. An MCO is considered to be qualified upon the issuance of a Certificate of Authority by the South Carolina Department of Insurance (SCDOI).

Potential MCOs who are not currently licensed as domestic insurers in the state of South Carolina should contact the SCDOI, Office of Company Licensing, to begin the process. Licensing information may be obtained by calling (803) 737-6221, or through the SCDOI's Web site, www.doi.sc.gov. The SCDHHS Office of Health Programs should not be contacted prior to obtaining a Certificate of Authority from SCDOI.

Once an MCO has obtained licensure from the SCDOI the MCO must apply for Medicaid enrollment at <https://providerservices.scdhhs.gov/ProviderEnrollmentWeb/>. During the enrollment process, the licensed potential MCO will be asked to provide the following information to SCDHHS.

1. SCDOI Certificate of Authority with a letter requesting inclusion
2. Business Plan

3. Ownership Disclosure (regardless of percentage of ownership)
4. Board Member Names and Qualifications
5. Officer Names and Qualifications
6. SCDOI Certificate of Authority
7. Financial Statements (bank account, line of credit, loans)
8. Office Location (physical address)

The above information must be housed in a binder with an attached USB flash drive of all materials. The number of binders (copies) and flash drives will be determined by SCDHHS.

After submission of these materials, SCDHHS will develop a project plan to include all elements potential MCOs will need to become a contracted SC Medicaid Managed Care Provider. Included with the project plan will be the requirement of the MCO to coordinate with the SCDHHS Division of Enterprise Systems to establish connectivity with the SCDHHS information system(s). All MCOs must undergo a Readiness Review with the SCDHHS External Quality Review Organization (EQRO). The Readiness Review for MCOs is conducted after SCDHHS has obtained, reviewed and approved all required submissions and associated Medicaid Management Information System (MMIS) activities required for operational readiness.

At the appropriate time, SCDHHS will authorize its EQRO to begin the Readiness Review of the potential MCO's operations. If deficiencies are noted during the review, the MCO will be required to submit a Plan of Correction (PoC) to SCDHHS. Time frames given for correcting deficiencies will be based on the severity and scope of the deficiencies.

The MCO is scored against a set of nationally recognized standards that represent SCDHHS' expectations for successful operation within the South Carolina Medicaid Program. SCDHHS will supply a copy of the most current version of the Readiness Review standards upon request. The review is conducted at the MCO's South Carolina location. It includes a desk review of the various Policies and Procedures, committee minutes, etc., as well as interviews with key staff members. The MCO will be expected to have a number of materials available during the review. The External Quality Review Organization (EQRO) will coordinate with the MCO to schedule the Review and to communicate the EQRO's expectations.

Upon receipt of the completed enrollment package and a signed contract, SCDHHS will forward the signed contracts to CMS for approval. Once CMS approval is granted, Managed Care staff will review service area networks submitted by the MCO and determine network adequacy. Along with the service area network submission, the MCO will provide an attestation letter confirming all Provider contracts are in compliance with the following state requirements:

- All contracts and amendments have been prior approved by SCDHHS

- All contracts have been properly signed and have an effective date
- All contracts include approved hold harmless language
- All contracts cover the services specified in the service area network submission
- All contracts (as appropriate) contain suitable documentation regarding hospital privileges, credentialing information and a listing of group practice members
- All contracts are, at a minimum, one year (12 months) in term. Contracts may be renewed after the first term using a contract amendment; however, the total contract period may not exceed a maximum of five (5) years.

The MCO will be able to begin enrolling Medicaid MCO Members following SCDHHS approval of the network. Timeframes for Medicaid MCO Member Enrollment will be determined and referenced on the project plan developed between the MCO and SCDHHS.

Information on reports, spreadsheets, and file layouts is located in this guide and the MCO Reports Companion Guide housed on the SCDHHS Web site at <https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp>

1.0 General Provisions

For all cites in Section 1.0, please refer to the contract for all requirements between MCO and SCDHHS.

2.0 Contractor Administrative Requirements

2.1 Delegation of Authority

For all cites in the Section 2.1, please refer to the contract for all requirements between MCO and SCDHHS.

2.2 Contractor Administration and Management

For all cites in Section 2.2.1 through Section 2.2.1.9, please refer to the contract for all requirements between MCO and SCDHHS.

Section 2.2.1.10: The MCO must submit an organizational chart annually and upon any changes to key staff. Annual submissions are due by September 30th and changes shall be submitted within ten (10) business days of the change. The submission shall be a graphical representation of the organization. All required key personnel and all departmental points of contact must be individually identified on the submission. Contact information for each of these positions including mailing address, email address, and telephone number is required for key personnel. The organizational chart must be submitted to the MCO's SharePoint annual library with notification to the account manager.

For all cites in Section 2.2.1.11 through Section 2.2.1.12, please refer to the contract for all requirements between MCO and SCDHHS.

Section 2.2.2 through Section 2.2.3.1: A curriculum vitae for all key personnel, defined in the contract as management and having a designation on the table as 1.0 FTE, are to be submitted to SCDHHS upon any changes to key management staff. Any changes to key staff shall be submitted to SCDHHS within ten (10) business days of the change. The curriculum vitae for each of the key personnel must be submitted to the MCO's SharePoint annual library with notification to the account manager.

The Department reserves the right to approve or disapprove all key personnel (initial or replacement) prior to their assignment with the MCO. SCDHHS will notify the MCO of any concerns it has with key personnel within ten (10) business days. If SCDHHS does not respond in writing to the MCO within ten business days, key personnel are considered approved.

The MCO must provide notice to the Department of any changes in management staff personnel, including a change in duties or time commitments. The MCO will assure the adequacy of its levels of staffing to properly service the needs of SCDHHS both upon contract initiation and the duration the contract is in effect.

For all cites in Section 2.2.4 through Section 2.2.4.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 2.2.4.4 through Section 2.2.4.5: The training plan and schedule required for submission to SCDHHS are for trainings done for the MCO's contracted Providers. The MCO must submit their intended training dates and materials to the MCO's SharePoint annual library no later than September 30th in each year of the contract thereafter. The information must include the dates, times, location and intended audience of each proposed training session. Notification to the account manager is required once the MCO has submitted this information to the MCO SharePoint annual library. Training schedule updates must be submitted at least thirty calendar days (30) prior to the intended training.

For all cites in Section 2.2.5 through Section 2.2.6.2, please refer to the contract for all requirements between MCO and SCDHHS.

2.3 Credentialing

For all cites in Section 2.3, please refer to Section 6 of this guide and the contract for all requirements between MCO and SCDHHS.

2.4 Subcontractor Requirements

Section 2.4.1.1: If the MCO decides to Subcontract service provision, it must have a properly executed contract with the Provider of those services. The contract must be for

at least 12 months (one year). SCDHHS will not accept Letters of Agreement (LOA), Memorandum of Understanding (MOU) or any variations of these types of agreements. Single case agreements are not prohibited under this section.

Section 2.4.2.1: SCDHHS has developed a standardized subcontract boilerplate insert for Providers who contract with Managed Care Organizations (MCOs). **Article I** encompasses all SCDHHS required language. (Language and definitions in this section cannot be altered, modified or changed by either the Provider or MCO.) Effective February 1, 2012, MCOs began implementation of this insert into their 2012 subcontract boilerplates and in the subsequent years' subcontract boilerplates.

Subcontracted Providers must understand and the MCOs must clarify with their subcontract providers that the subcontractor is not entitled to a State Fair Hearing process for denied claims, payment disputes, administrative or medical determination by the MCO unless it is in support of a Member Appeal.

Section 2.4.2.2: Changes to Approved Model Subcontracts for Direct Service Provision

Should an MCO modify a previously approved Provider boilerplate Subcontract, it must submit a redline version of the Subcontract to SCDHHS for approval prior to execution by either party. Provider for this section is defined as any person or entity that provides a direct service to a Medicaid member. The submission must be electronic and in the format required by SCDHHS. The electronic redline contract submission must contain the following information:

- An electronic redline version of the Subcontract showing all requested language changes and deviations from the approved model
- Headers, completed reimbursement page, completed information of Subcontract facility(ies) including locations, complete Provider information including location(s), attachments or amendments, and the projected execution date of the Subcontract
- Covered Programs (*i.e.*, Healthy Connections)
- Footer information containing the original model Subcontract approval number and date

Once the redlined Subcontract has been given tentative approval by SCDHHS, the footer information will be changed to a tracking number provided by SCDHHS. The MCO must submit a black-line copy of the tentatively approved redlined Subcontract for final approval. Once final approval has been given, the MCO and Subcontractor may execute the Subcontract. SCDHHS reserves the right to examine credentialing information prior to execution of the Subcontract. MCOs must provide proof it has checked the Excluded Parties List Service administered by the General Services Administration. This documentation shall be kept in the Provider's file maintained by the MCO.

MCOs are required to update their contract boilerplate after changes have been made to the SCDHHS contract that amends Article I boilerplate language. These updates must be submitted to SCDHHS within forty-five (45) calendar days after the new contract or amendment that includes changes to **Article I** with SCDHHS have been signed by the MCO.

MCO Communications to SCDHHS Regarding Network Provider Changes

Should an MCO terminate a contract with an MCO Provider(s) who is 1) a status number one (#1) on the Network Provider and Subcontractor Listing Spreadsheet, or 2) are the sole network Provider of that service in a county or surrounding area, the MCO shall copy its SCDHHS program manager in all termination notification correspondence (either written or electronic). Also, should an MCO receive notice of termination from a Provider who meets the qualifications listed above, the SCDHHS program manager shall be notified immediately (written or electronic).

Should the MCO want to amend any sections of the subcontract with the subcontracted Provider, any amendment, including reimbursement methodology or amounts, shall be sent to SCDHHS for review at least thirty (30) days prior to the effective date of the amendment.

2.5 Immunization Data and Federal Funds Restrictions

For all cites in Section 2.5 through Section 2.5.2.1, please refer to the contract for all requirements between MCO and SCDHHS.

2.6 Provider Enrollment

For all cites in Section 2.6.1 through Section 2.6.3.3.2, please refer to the contract for all requirements between MCO and SCDHHS.

3.0 Eligibility and Enrollment

3.1 Enrollment

Section 3.1.1: This program is limited to certain Medicaid beneficiaries who:

- Do not also have Medicare
- Are under the age of 65
- Are not in a nursing home
- Are not in a limited benefit category
- Are not participating in a Home or Community Based Waiver program
- Are not participating in Hospice
- Are not participating in the PACE program

Managed Care Organizations Policy and Procedure Guide

- Do not have HMO third party coverage
- Are not enrolled in another Medicaid managed care plan

The table below reflects those eligibility categories that are mandatorily assignable (green), choice only (yellow), or non-managed care eligible (red). Eligibility categories are available on the MCO's 834. The recipient special program (RSP) categories for each Medicaid beneficiary may be identified on the Medicaid Provider web portal at <https://portal.scmehicaid.com/>.

Managed Care Eligibility and Eligibility Categories

Eligible for Mandatory Assignment Requires Participation MCO	
11	MAO (Extended/Transitional)
12	OCWI (Infants)
16	Pass Along Eligibles
17	Early Widows/Widowers
18	Disabled Widows/Widowers
19	Disabled Adult Children
20	Pass Along Children
32	Aged, Blind Disabled (ABD) (Over Age 18)
40	Working Disabled
59	Low Income Families
71	Breast and Cervical Cancer
80	SSI (Over Age 18)
81	SSI w/Essential Spouse (Over Age 18)
87	OCWI Pregnant Women/Infants
88	OCWI Partners for Healthy Children
91	Ribicoff Children

Voluntary Enrollment Only Choice of Managed Care or Fee For Service	
13	MAO (Foster care/Adoption)
31	Title IV-E Foster Care
32	Aged, Blind Disabled (ABD) (Under Age 19)
51	Title IV-E Adoption Assistance
57	Katie Beckett/TEFRA
60	Regular Foster Care
61	Adult Former Foster Care
80	SSI (Under Age 19)
81	SSI w/Essential Spouse (Under Age 19)
85	Optional Supplement
86	Optional Supplement & SSI
RSP	Description
ISED	Interagency Sys. Of Care for Emotionally Disturbed Children
CHPC	Children's Personal Care
MCPC	Intergrated Personal Care Services
FOST	Foster Care Children
	Members who are indians and part of a federally recognized tribe

Not Eligible to Participate in Managed Care	
10	MAO (Nursing Home)
14	MAO (General Hospital)
15	MAO (Waivers-Home and Community)
33	ABD Nursing Home
48	Qualified Individuals (OI)
50	Qualified Disabled Working Individual
52	SLMB
54	SSI Nursing Home
55	Family Planning
70	Refuge Entrant
90	Qualified Medicare Beneficiary
Limited Benefit Indicators: E, I, C, D, J, P, A	
RSP	Description
MCSC	Program For All Inclusive Care for the Elderly (PACE)
AUTW	Pervasive Developmental Disorder Waiver
CLTC	Community Choices Waiver
CSWE	Community Supports Waiver-Est.
CSWN	Community Supports Waiver-New
DMRE	Intellectually Disabled/Related Disability Waiver-Est.
DMRN	Intellectually Disabled/Related Disability Waiver-New
HSCE	Head and Spinal Cord Waiver-Est.
HSCN	Head and Spinal Cord Waiver-New
HIVA	HIV/AIDS Waiver
TBRS	Tuberculosis Program
VENT	Mechanical Ventilator Dependent Waiver
PRTF	Psychiatric Residential Treatment Facility
MCHS	Hospice
	Dual Eligibles (Medicare/Medicaid)
	Beneficiaries who have private managed care insurance (HMO)

3.2 Enrollment Process

Section 3.2.1 through Section 3.2.3.1: SCDHHS has instituted an enrollment process for Medicaid managed care called South Carolina Healthy Connections Choices (SCHCC). SCDHHS currently contracts with a third party Enrollment broker. Additional details on SCHCC may be found at www.scchoices.com. Newly eligible Medicaid beneficiaries who also meet the criteria for Medicaid managed care participation will be informed of their managed care choices. Before being assigned to a plan by SCHCC, beneficiaries who are participating in the yearly eligibility determination and continue to be eligible for

plan assignment are given at least an initial thirty (30) days to choose an MCO. Newly Medicaid enrolled beneficiaries have an initial sixty (60) days to choose an MCO. Medicaid members that are mandatorily assignable who do not choose a managed care plan will be auto assigned based on the algorithm described in Section 3.2.3.2.5.

Current Medicaid Beneficiaries that have the option to enroll with a managed care plan may enroll any time. Once a person has initially joined or been assigned to a Managed Care Plan, they have ninety (90) days in which they may transfer to another plan without cause. This may only be done once during their yearly enrollment period. After the ninety (90) day choice period has expired, Medicaid MCO Members must remain in their health plan until their one year anniversary date, unless they have a special reason to make a change (See the Disenrollment section for details).

The act of Medicaid and managed care enrollment is to be exclusively conducted by SCDHHS and its contracted enrollment broker. Please see section 3.7 regarding MCO allowed activities regarding enrollment.

For all cites in Section 3.2.3.2 through Section 3.2.3.2.4, please refer to the contract for all requirements between MCO and SCDHHS.

Section 3.2.3.2.5 through Section 3.2.4.3.2: Enrolling Eligibles in Contractor's Plan-Quality Weighted Auto Assignments.

Member Auto-Assignment (Non-Newborns)

SCDHHS, through its Enrollment Broker, enrolls beneficiaries in a managed care organization (MCO). Beneficiaries that are designated as "Assignable" (See "Managed Care Eligibility and Eligibility Categories" table in Section 3.1 of the Policy and Procedure Manual) will be enrolled through the following methodology:

1. The member may contact the enrollment broker and choose an MCO at which point the broker will enroll the member in the chosen MCO. The enrollment will be effective on the first day of the next available enrollment month.
2. Members that do not choose an MCO, but have either (1) been previously enrolled with an MCO in the past year or (2) have immediate family members enrolled with an MCO, will be assigned to that MCO.
3. Member that are not enrolled through one of the processes above will be assigned using a Quality Weighted Assignment algorithm.

MCOs with the designation of a Health Maintenance Organization (HMO) by the Department of Insurance and designated as a Managed Care Organization (MCO) with SCDHHS are required to have a Quality Weighted Assignment Factor.

The Quality Weighted Assignment algorithm is linked to an MCO's Overall Score on the MCO Report Card. The algorithm is updated annually effective for assignments beginning on January 1st and members are assigned as follows:

MCO RATING ON REPORT CARD	QUALITY WEIGHTED ASSIGNMENT FACTOR
5 Stars (90 th percentile or above)	2.5
4 Stars (75 th – 89 th percentile)	2.5
3 Stars (50 th – 74 th percentile)	1.5
2 Stars (25 th – 49 th percentile)	1.0
1 Star (below 25 th percentile)	0

The Quality Weighted Assignment Factors (QWAF) listed above represent the assignment factors associated with each MCO rating on the report card. A two star rated MCO will receive one (1) member; a three star rated will receive one and a half (1.5) members for each member that a two star receives; a four and five star rated MCO will receive two and a half (2.5) members for each member that a two star receives.

The Quality Weighted Assignment formula is as follows:

$$\frac{(\# \text{assignable members in county})}{((\# \text{plans in county @ 2 stars} * 2) + (\# \text{plans in county @ 3 stars} * 3) + (\# \text{plans in county @ 4 stars} * 5) + (\# \text{plans in county @ 5 stars} * 5))}$$

Variables:

Assignable members in county: 1000

Plans @ 2 stars: 5

Plans @ 3 stars: 1

Plans @ 4 stars: 0

Plans @ 5 stars: 0

Value of 1 star:

$$((1000)/((5*2)+(1*3)+(0*4)+(0*5))) = 1000/10+3+0+0 = 1000/13 = 77 \text{ per } 1,000 \text{ Assignees}$$

So, to allocate the total 1,000 members to the MCOs using the algorithm:

$$2 \text{ star MCOs get } 2*77 = 154 \text{ each MCO} * 5 \text{MCOs} = 770$$

$$3 \text{ star MCOs get } 3*77 = 231 \text{ each MCO} * 1 \text{MCO} = 231$$

$$\text{Total Assigned} = 770 + 231 = 1001 \text{ (rounded down to } 1000)$$

The following terms apply to MCOs:

- 1. Established MCOs:** An established MCO is one that has a MCO report card rating. Established MCOs will receive member assignments based on the Quality

Weighted Assignment Factor linked to their MCO rating on the latest Report Card.

2. **New MCOs:** A new MCO is one that has not had a MCO report card rating. New MCOs will receive member assignments based on the Quality Weighted Assignment Factor for a three star MCO (default rating) until the new MCO receives a report card rating. The default rating will be labeled “New Plan Not Yet Rated” in materials that are available to the public.
3. **Merger or the acquisition of MCOs:** In the event of a merger or acquisition of MCOs, the Quality Weighted Assignment Factor of the resulting MCO will be calculated as follows:
 - a. **Acquisitions:** In the event of an acquisition, the resulting combination of MCOs shall be assigned the MCO Star Rating of the Acquiring Plan. The QWAF associated with that star rating shall be applied during the assignment process.
 - b. **Mergers:** In the event of a merger, the resulting combination of MCOs shall be assigned a MCO Star Rating equal to the sum of the weighted average star ratings of all MCOs included in the merger. The MCO Star Rating for a merger shall be calculated as follows:
 1.
$$\frac{((\text{MCO Star Rating for Plan "X"}) * (\# \text{ members in Plan "X"})) + ((\text{MCO Star Rating for Plan "Y"}) * (\# \text{ members in Plan "Y"}))}{\text{Total Members in both Plans}}$$
 2. MCO Star Ratings are whole number ratings. Any weighted average star rating resulting from the calculation above with a decimal value of .50 or greater, will be rounded up to the nearest whole number (2.5 rounds up to 3.0) and any weighted average star rating with a decimal value less than .50, will be rounded down to the nearest whole number (2.499 rounds down to 2.0).

When applying the Quality Weighted Assignment algorithm, the enrollment broker must apply the formula based on the geographic service area for each MCO, since each MCO might not participate in all geographic service areas

For all cites in Section 3.2.5. through Section 3.2.6.7, please refer to the contract for all requirements between MCO and SCDHHS.

Section 3.2.7 through Section 3.2.7.4: The MCO is responsible for notifying the Department of the birth of an unlinked newborn to an enrolled member or a reporting error related to a newborn. Some examples of newborn errors include the enrollment of a newborn into an incorrect health plan, enrollment with an incorrect effective date, and linkage to an incorrect mother’s Medicaid ID.

Newborn errors must be reported using the web-based notification portal located on the SCDHHS website (<https://training.scdhhs.gov/mc/?q=node/6>).

All required fields on the web-based form must be completed with the appropriate Medicaid information in order for SCDHHS to act on the request. The MCO must submit the completed form by clicking the *Submit* button on the bottom of the web-based notification form. SCDHHS will research the request and take appropriate action. SCDHHS staff will reply to the MCO's request via email with the outcome of the request.

MCO maternity kicker payments are processed as part of the monthly capitation payment process for newborns linked to an MCO-enrolled mother. The automated capitation payment process will include a maternity kicker payment upon the initial linkage of a newborn and mother, providing that the linkage occurs during the first three (3) months of the newborn's life.

For those cases where the MCO did not receive a maternity kicker payment through the automated/systemic process, and in cases where there is a stillborn birth, the MCO of the enrolled mother must submit the *Maternity Kicker Reporting Template* found in the report companion guide and at the following location, <https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates> in order to request payment. SCDHHS will process the request and remit payment for each entry on the template that includes **both the Mother's Medicaid ID and the Newborns Medicaid ID for any entry that is not a stillborn entry.** If the template contains incomplete or inaccurate information, SCDHHS will not process a maternity kicker. The MCO is expected to work with the MCATS eligibility team to obtain accurate and complete information on newborns and this information is used to process the maternity kickers.

SCDHHS will process requests for payment of stillborns submitted on the template if it is able to confirm that the mother was pregnant. This validation will match the mother's Medicaid ID submitted on the template to an existing encounter submitted by the MCO. If SCDHHS cannot confirm a pregnancy for any stillborn entry after review of the mother's Medicaid ID, the SCDHHS program representative will return the request and ask for additional information confirming the pregnancy of the member.

Requests for manual maternity kicker payments may only be made between the fourth and sixth month after birth (to enable the automated process to capture these payments). SCDHHS, at its discretion, may consider payments beyond this timeline. Completed forms are to be uploaded to the Department's SharePoint site in the MCO's monthly libraries. Once uploaded to SharePoint the Department will review the submissions for appropriateness and submit a Gross Level Adjustment for any maternity kicker payments due to the MCO. A copy of the MCO's submitted Maternity Kicker Template will be returned to the MCO upon processing of the requests. Any payments made will be indicated on the form.

3.3 Disenrollment Process

For all cites in Section 3.3.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 3.3.2 through Section 3.4.3: Disenrollments may be initiated by (1) the Medicaid MCO Member, (2) SCDHHS, or (3) the MCO. Member-initiated Disenrollment is addressed above in the section entitled **Enrollment Process**.

The MCO may contact Medicaid MCO Members, who are new to the MCO, upon receipt of the monthly member listing file; however, follow up must be within the guidelines outlined in this guide.

A Medicaid MCO Member who becomes disenrolled due to loss of Medicaid eligibility, but regains Medicaid eligibility within sixty (60) calendar days will be automatically re-enrolled in the MCO's plan. Depending on the date eligibility is regained, there may be a gap on the Medicaid MCO Member's MCO coverage. If Medicaid eligibility is regained after sixty (60) calendar days, the reinstatement of Medicaid eligibility will prompt the SCDHHS Enrollment broker to mail an Enrollment packet to the Beneficiary. The Beneficiary may also initiate the re-enrollment process without an enrollment packet.

The SCDHHS will notify the MCO of the Medicaid MCO Member's Disenrollment due to the following reasons:

- Loss of Medicaid Eligibility or loss of Medicaid MCO program Eligibility
- Death of a member
- Member's intentional submission of fraudulent information
- Member becomes an Inmate of a Public Institution (See Appendix A – Definition of Terms.)
- Member moves out of state
- Member elects Hospice
- Member becomes Medicare Eligible
- Member becomes institutionalized in a Long-Term Care facility or nursing home for more than ninety (90) continuous days
- Member elects home and community based waiver programs
- Loss of Medicaid MCO participation
- Member becomes age 65 or older
- Enrollment in a commercial HMO
- Member is placed out of home [*i.e.*, Intermediate Care Facility for the Mentally Retarded (ICF/MR), Psychiatric Residential Treatment Facility (PRTF)]
- Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the MCO's ability to furnish services to the member or other enrolled members

The MCO shall immediately notify SCDHHS when it obtains knowledge of any Medicaid MCO Member whose Enrollment should be terminated prior to SCDHHS's knowledge.

The MCO may request Disenrollment of a Medicaid MCO Member based upon the following reasons:

- MCO ceases participation in the Medicaid MCO program or in the Medicaid MCO Member's service area
- Member dies
- Member becomes an Inmate of a public institution
- Member moves out of state or MCO's service area
- Member elects Hospice
- Member becomes institutionalized in a Long-Term Care facility/nursing home for more than ninety (90) continuous days
- Member elects home- and community-based Waiver programs
- MCO determines member has Medicare coverage
- Member becomes age 65 or older
- Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the MCO's ability to furnish services to the member or other enrolled members
- Member is placed out of home [*i.e.*, Intermediate Care Facility for the Mentally Retarded (ICF/MR), Psychiatric Residential Treatment Facility (PRTF)]

The MCO's request for Medicaid MCO Member Disenrollment must be made in writing to South Carolina Healthy Connections Choices (SCHCC). The request must state, in detail, the reason for Disenrollment. SCHCC will log this request and forward it to SCDHHS for review. SCDHHS will determine if the MCO has shown good cause to disenroll the Medicaid MCO Member and SCDHHS will give written notification to the MCO and the Medicaid MCO Member of its decision. During this process, SCDHHS may request the MCO to provide additional information and documentation. The MCO and the Medicaid MCO Member shall have the right to appeal any adverse decision. The form for disenrollment must be completed and may be found either on the SCDHHS website at <https://msp.scdhhs.gov/managedcare/site-page/reference-tools> or at www.scchoices.com. Please follow the instructions on the form at these links in completing and sending the form for disenrollment.

The MCO may not request Disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's 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 Plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

The same time frames that apply to Enrollment shall be used for changes in Enrollment and Disenrollment. If a Medicaid MCO Member's request to be disenrolled or change MCO plans is received and processed by SCDHHS by the internal cut-off date for the

month, the change will be effective on the last day of the month. If the Medicaid MCO Member's request is received after the internal cut-off date, the effective date of the change will be no later than the last day of the month following the month the Disenrollment form is received. A Medicaid MCO Member's Disenrollment is contingent upon their "lock-in" status (See the **Enrollment Process** section).

3.4 Notification to MCO of Membership

For Section 3.4.1, please refer to the contract for all requirements between MCO and SCDHHS.

For Section 3.4.2, please refer to the report companion guide for the 834 record layout from the enrollment broker.

For Section 3.4.3, please refer to the contract for all requirements between MCO and SCDHHS.

3.5 Maximum Enrollment

For all cites in Section 3.5, please refer to the contract and to the descriptions outlined in Section 3.0 of this guide for all requirements between MCO and SCDHHS.

3.6 Suspension and/or Discontinuation of Enrollment

Section 3.6.1 through Section 3.6.2: The Department will make a determination of network adequacy at the its discretion.

For all cites in the Section 3.6.3 through Section 3.6.3.4, please refer to the contract for all requirements between MCO and SCDHHS.

3.7 Redetermination Notice

Section 3.7.1: This is a file created at the SCDHHS cutoff date, normally the third Thursday in any given month. This listing describes those members who are due for redetermination of eligibility. These recipients are reviewed and if necessary reinstated.

Two files are produced for redetermination and posted to the MCO's EDI box:

- 1. MEDS File:** &<hlq>.vendor-ID.REVIEW.FILE and &<hlq>.vendor-D.REVIEW.FILE.MCF
- 2. CURAMFile:** &<hlq>.vendor-ID.REVIEWC.FILE and &<hlq>.vendor-ID.REVIEWC.FILE.MCF

Please see the report companion guide for additional information.

For all cites in Section 3.7.2 through Section 3.7.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 3.7.4: SCDHHS will place two (2) monthly files in the MCO's secure ftp site that detail the members whose Healthy Connections eligibility is scheduled to terminate in two (2) months. One (1) file is generated from the MEDS eligibility system and the other file is generated from the CURAM eligibility system. Please see file names above.

MCOs are encouraged to outreach to members on the monthly redetermination file prior to the stated termination date; encouraging them to complete their redetermination documents and return them promptly to SCDHHS.

MCOs may also outreach to members from the monthly redetermination file after their termination date for the sole purpose of encouraging the member to complete their enrollment package and submit it to SCDHHS for processing if they have not already done so. The MCO may outreach to a member on the monthly redetermination file up to 75 days after the planned disenrollment date from Healthy Connections. This process is intended to encourage the member to regain their Healthy Connections eligibility. The MCO may not discuss enrollment or transfers with the member but may provide assistance in completing the form. The MCO may also encourage the member to contact the SCDHHS Member Services Call Center at 1-888-549-0820 for further assistance.

3.8 Member Call Center

For all cites in Section 3.8.1 through 3.8.2.6.14, please refer to the contract for all requirements between MCO and SCDHHS.

Section 3.8.3 through 3.8.3.7: MCOs are required to submit a monthly member and provider call center reports. These reports are reflected in the managed care report companion guide. MCOs shall submit this report to the agencies SharePoint site in the MCO's monthly library.

3.9 Member Handbook

The MCO shall maintain an organized, integrated member services function to assist Medicaid MCO Members in understanding the MCO's policies and procedures. The function of the member services unit is to provide additional information about the MCO's Providers, facilitate referrals to Providers, and assist in the resolution of service and/or medical delivery concerns or problems. The MCO shall identify and educate its Medicaid MCO Members who access the system inappropriately and provide additional education, as needed. The MCO shall provide a written description of its member services functions to its Medicaid MCO Members no later than fourteen (14) business days from receipt of Enrollment data from SCDHHS. This written description may be included in the member handbook and must include the following information:

Member Handbook Contents
Specific information on Core Benefits
Approved expanded benefits

Member Handbook Contents
Out-of-plan (Fee-For-Service) services or benefits
Non-Covered Services
A glossary/definition of generic MCO terms
A description of how the plan operates
An explanation of how the plan's identification (ID) card works
A description of the WIC program
A description of the plan's well-child program
Comprehensive instructions on how to obtain medical care
Information reminding pregnant Medicaid MCO Members that their Newborn will be automatically enrolled in the plan for the first ninety (90) calendar days from birth unless the mother indicates otherwise prior to delivery
Instructions on how to choose a Primary Care Provider
Instructions on the plan's Prior Authorization process
Information on the plan's pharmacy formulary and authorization policies
Instructions/procedures for making appointments for medical care
Instructions on accessing the MCO's Member services departments
Information on the responsibilities and rights of an MCO Member
An explanation of its confidentiality of Medical Records
Information on member Disenrollment and termination
An explanation of the Medicaid MCO Member(s) effective date of enrollment and coverage
The plan's toll-free telephone numbers

For all cites in Section 3.9.1.1 through Section 3.9.1.31.3, please refer to the contract for all requirements between MCO and SCDHHS.

3.10 Provider Directory

Section 3.10.1 through Section 3.10.3.2: The MCO must provide a full Provider directory monthly to SCDHHS in the MCO's SharePoint monthly library.

The format for the Provider directory will be the same as that submitted to the Enrollment broker. Formats will be provided in the report companion guide.

For all cites in Section 3.10.4 through Section 3.10.6.2, please refer to the contract between SCDHHS and MCO.

3.11 Billing and Reconciliation

For all cites in Section 3.11, please refer to the contract for all requirements between MCO and SCDHHS.

3.12 Member Education

For all cites in Section 3.12.1 through Section 3.12.6.2, please refer to the contract between SCDHHS and MCO.

Section 3.12.6.3: The MCO's written materials and education must include:

- A definition of the terms "Emergency Medical Care" and "Urgent Medical Care" and the procedures on how to obtain such care within and outside of the MCO's Service Area.
- The MCO must provide a description of its Family Planning Services and services for communicable diseases such as TB, STD, and HIV/AIDS. The description must include a statement of the Medicaid MCO Member's right to obtain Family Planning Services from the plan or from any approved Medicaid enrolled Provider. Also included must be a statement of the Medicaid MCO Member's right to obtain TB, STD, HIV/AIDS services from any state public health agency.
- Summary documents and brochures must include a statement that the document may contain only a brief summary of the plan and that detailed information can be found in other documents, e.g., Member Handbook, or obtained by contacting the plan.

These written materials requirements may be fulfilled by including this material in the MCO's member handbook.

For all cites in Section 3.12.7 through Section 3.12.8.1, please refer to the contract between SCDHHS and the MCO.

3.13 Member Communication

Section 3.13.1.1 through 3.13.1.2.4: New or revised_Member materials should be uploaded to the MCO's SharePoint site in the PR and Member Material Review library. All files submitted should have the following standard naming convention:

Document Labeling: Plan Code + Date of 1st submission + Type + Sequence #

Plan Code: ATC (Absolute Total Care), Advicare (AD), BC (BlueChoice Medicaid), Molina (MO), Select Health (FC), WellCare (WC)

Date: MMDDYYYY

Type: M=Member, P=Provider, PR=Marketing Material

Appending Type: S=Spanish

Initial Member Material Submission:

Example: ATC-01182015-M-1

Example Definition: Absolute Total Care member material submission on 1/18/2015

initial submission.

Resubmissions:

Plan Code + Date of 1st submission + Type + Sequence #.Version#

Example: ATC-01182015-M-1.1

Example Definition: Absolute Total Care member material submission on 1/18/2015 1st resubmission.

Spanish Material:

Plan Code + Date of 1st submission + Type-Sequence # + Appending Type.Version#

Example: ATC-01182015-M-1-S.2

Example Definition: Absolute Total Care Spanish member material submission on 01/18/2015 1st resubmission.

For all cites in Section 3.13.1.2 through Section 3.13.2.1, please refer to the contract between SCDHHS and the MCO.

3.14 Enrollment and Disenrollment Process

For all cites in Section 3.14, please refer to the contract between SCDHHS and the MCO.

4.0 Services

4.1 Core Benefits for the South Carolina Medicaid MCO Program

SCDHHS recognizes that certain medical situations may occur from time to time, where medical policy is not clearly defined. In those cases SCDHHS will deal with them on a case-by-case basis. Until such a decision is rendered by SCDHHS, the responsibility of costs will remain with the plan.

It is the responsibility of the plan to notify SCDHHS as soon as they become aware of such a situation.

The following list of services and benefits are consistent with the outline and definition of Covered Services in the Title XIX SC State Medicaid Plan. MCO plans are required to provide Medicaid MCO Members “medically necessary” care, at the very least, at current limitations for the services listed below. Unless otherwise specified, service limitations are based on the State Fiscal Year (July 1 - June 30). While appropriate and necessary care must be provided, MCOs are not bound by the current variety of service settings. More detailed information on Medicaid policy for services and benefits may be found in the corresponding Provider Manual for each service and provider type. These manuals are available electronically on the SCDHHS website at <https://www.scdhhs.gov/>.

MCO plans may offer additional services to Medicaid MCO members. Changes or deletions to the additional services made during the contract year must be submitted to SCDHHS for approval. These additional services may include medical services which are currently non-covered and/or which are above current Medicaid limitations

SCDHHS, on a regular basis, may expand, limit, modify or eliminate specific services, procedures and diagnosis codes offered by the SC Medicaid program. These changes may also affect maximum reimbursement rates and service limitations. These changes are documented and distributed via Medicaid bulletins and Provider manual updates. They may also be reflected, depending on the nature of the change, in the MCO Fee Schedule and Contract Rate Schedule, which are provided electronically to each MCO on a monthly basis. Please consult the latest monthly electronic Fee Schedule and Contract Rate Schedule for up to date coverage, pricing and limitations.

In the event the amount, duration and/or scope of services are modified under the Medicaid fee-for-service program, SCDHHS, at its discretion, may exempt the Medicaid MCO Program from the modification.

Table 4.1 — Core Benefits

MCOs must provide the following Core Benefits listed in Table 4.1 under section 4.1.2.

Ambulance Transportation

All 911 based emergency transportation services provided via ambulance, air ambulance, and/or medivac (Provider type 82) are the responsibility of the MCO.

In the event an ambulance is called to a location but not used for transport (i.e., the Medicaid MCO Member is not taken to a medical services Provider), the MCO is still responsible for payment to the Provider. Specific requirements for ambulance services may be found in the Ambulance Provider Manual at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins.

Transportation for Out-of-State Medical Services

Medicaid MCO Members are eligible for pre-authorized transportation as described below:

- If the MCO authorizes out-of-state referral services and the referral service is available in-state, the MCO is responsible for all Medicaid covered services related to the referral to include all modes of transportation, escorts, meals, and lodging.
- If the MCO authorizes out-of-state services and the service is not available in-state, the MCO will be responsible for the cost of referral services and any ambulance or Medivac transportation.

Back Transfers

The MCO is expected to coordinate the transfer of Members from one hospital to another hospital, or from a hospital to a lower level of care, when requested by the Provider. The MCO must consider social reasons in the transfer request (e.g., so a Member can be closer to a family support system, etc.). MCOs are not allowed to deny a transfer solely due to these social reasons

The decision on when and to what level of care a Member is to be transferred is solely that of the attending physician. Transfer coordination from point A to point B is initiated by the Provider with MCO support upon request.

The MCO will cover the costs of transfer consistent with the Member's benefits and utilize the transport services agreed to by the state.

Ancillary Medical Services

Ancillary medical services, including, but not limited to pathology, radiology, emergency medicine, inpatient, outpatient and ambulatory surgical center charges for dental services, and anesthesiology are part of the managed care organizations coverage array.. When the Medicaid MCO Member is provided these services the MCO shall reimburse these services at the Medicaid fee-for-service rate, unless another reimbursement rate has been previously negotiated. Prior Authorization for these services shall not be required of either network or non-participating Providers. All anesthesia services, even those associated with behavioral health and dental procedures provided in an inpatient facilities, operating rooms, and ambulatory surgical centers, are the responsibility of the MCO.

Audiological Services

Audiological services include diagnostic, screening, preventive, and/or corrective services provided to individuals with hearing disorders, or for the purpose of determining the existence of a hearing disorder by or under the direction of an Audiologist. A physician or other Licensed Practitioner of the Healing Arts (LPHA), within the scope of his or her practice under state law, must refer individuals to receive these services. A referral occurs when the physician or other LPHA has asked another qualified healthcare Provider to recommend, evaluate, or perform therapies, treatment or other clinical activities to or on the behalf of the member and includes any necessary supplies and equipment. Audiological Services involve testing and evaluation of hearing-impaired children less than 21 years of age who may or may not be improved with medication or surgical treatment. This includes services related to hearing aid use.

The MCO is responsible for providing a range of examinations, fittings and related audiological services. The specific Medicaid procedures and limitations are listed in the Private Rehabilitative Therapy and Audiological Services Provider Manual at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins at any time.

Chiropractic Services

Chiropractic services are available to all beneficiaries. Chiropractic services are limited to manual manipulation of the spine to correct a subluxation. Chiropractic visits are counted separately from the ambulatory visit limit. Specific requirements for Medicaid chiropractic services may be found in the Physicians Provider Manual at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins.

Communicable Disease Services

An array of communicable disease services are available to help control and prevent diseases including but not limited to TB, syphilis, and other sexually transmitted diseases (STD's) and HIV/AIDS. Communicable disease services include examinations, assessments, diagnostic procedures, health education and counseling, treatment, and contact tracing, according to the Centers for Disease Control (CDC) standards. In addition, specialized outreach services are provided such as Directly Observed Therapy (DOT) for TB cases.

Eligible members should be encouraged to receive TB, STD, and HIV/AIDS services through their Primary Care Provider or by appropriate referral to promote the integration/coordination of these services. However, all members have the freedom to receive TB, STD and HIV/AIDS testing and counseling services from any public health agency without any restrictions.

If the Medicaid MCO Member receives these services through the MCO Primary Care Provider, the MCO is responsible for reimbursement of the services. If the Medicaid MCO Member receives these services outside the MCO network, Providers will be reimbursed through the Fee-For-Service system

Disease Management

Disease Management is a set medically necessary interventions designed to improve and maintain the health of Medicaid MCO beneficiaries. Disease management includes the coordination, monitoring, and education of MCO beneficiaries to maximize appropriate self-management.

Durable Medical Equipment

Durable medical equipment is equipment and supplies that provide therapeutic benefits or enables a beneficiary to perform certain tasks he or she would otherwise be unable to undertake due to certain medical conditions and/or illnesses. Durable medical equipment and supplies is primarily and customarily used for medical reasons, and is appropriate and suitable for use in the home. This includes but is not limited to medical products; surgical supplies; and equipment such as wheelchairs, traction equipment, walkers, canes, crutches, ventilators, prosthetic and orthotic devices, oxygen, hearing

aid services (provided by MCO only), and other medically needed items when ordered by a physician as Medically Necessary in the treatment of a specific medical condition.

The Medicaid MCO Member's prognosis is a deciding factor in approving equipment rental versus purchase. The MCO is responsible for informing Medicaid MCO Members and Providers of their policy regarding rental and/or purchase of equipment. Luxury and deluxe models are restricted if standard models would be appropriate.

Should a Medicaid beneficiary change MCO's, the new MCO is required to honor existing Prior Authorizations for Durable Medical Equipment and supplies for a period of no less than thirty (30) days. Specific requirements for Medicaid Durable Medical Equipment services may be found in the DME Provider Manual at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins.

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

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

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

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

The MCO is responsible for assuring that children through the month of their 21st birthday are screened according to the American Academy of Pediatrics (AAP) periodicity schedule. The periodicity schedule is available at the AAP website, <http://aappolicy.aappublications.org/cgi/reprint/pediatrics;105/3/645.pdf>. Specific Medicaid EPSDT requirements may be found in Section 2 of the Physician Provider Manual at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins.

Family Planning

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

Eligible Beneficiaries should be encouraged to receive Family Planning Services through an in network Provider with the MCO or by appropriate referral to promote the integration/coordination of these services. However, eligible beneficiaries have the freedom to receive Family Planning Services from an appropriate Provider without restrictions. If the Medicaid MCO beneficiary receives these services through an in-network or an out of network Provider, the MCO is responsible for reimbursement for the services. The Medicaid MCO Member may also receive these services from the Department of Health and Environmental Control (DHEC).

For a detailed policy information regarding Family Planning services please see the [Physicians, Laboratories, and Other Medical Professionals Provider Manual](https://www.scdhhs.gov/) at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins.

Hearing Aids and Hearing Aid Accessories

The MCO is responsible for providing hearing aids and hearing aid accessories to MCO Medicaid Members under age 21. The specific products and limitations are listed in the DME Provider manual at <https://www.scdhhs.gov/> and updated via Medicaid bulletin.

Home Health Services

Home Health services are healthcare services delivered in a person’s place of residence, excluding nursing homes and institutions, and include intermittent skilled nursing, home health aide, physical, occupational and speech therapy services, and physician ordered supplies. MCOs will be responsible for providing incontinence supplies to any enrolled members meeting medical necessity criteria for these services. The specific policies are listed in the Home Health Manual at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins.

Hysterectomies, Sterilizations, and Abortions

The MCO shall cover sterilizations, abortions, and hysterectomies pursuant to applicable Federal and State laws and regulations. When coverage requires the

completion of a specific form, the form must be properly completed as described in the instructions with the original form maintained in the Medicaid MCO Member's medical file and a copy submitted to the MCO for retention in the event of audit. In the event the requesting physician does not complete and submit the required specific forms referenced above, it is permissible for the MCO to delay or reject payment until such time as the forms are properly completed and submitted.

The following are applicable current policies:

Hysterectomies

The MCO must cover hysterectomies when they are non-elective and medically necessary. Non-elective, medically necessary hysterectomies must meet the following requirements:

1. The individual or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
2. The individual or her representative, if any, must sign and date an acknowledgment of receipt of hysterectomy information on the Consent for Sterilization form (DHHS Form 1723) prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age. DHHS Form 1723 can be found in [Physicians Services](#) and [Hospital Services](#) provider manuals.
3. The hysterectomy acknowledgment form is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.
4. The acknowledgment form is not required if the individual was already sterile before the hysterectomy or the individual required a hysterectomy because of a life threatening emergency situation in which the physician determined that prior acknowledgment was not possible. In these circumstances, a physician statement is required.
5. Hysterectomies shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.
6. Hysterectomies shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

Sterilizations

Non-therapeutic sterilization must be documented with a completed Consent Form which will satisfy federal and state regulations. Sterilization requirements include the following:

1. Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing.

2. The individual to be sterilized shall give informed consent not less than thirty (30) full calendar days (or not less than seventy-two (72) hours in the case of premature delivery or emergency abdominal surgery) but not more than one hundred eighty (180) calendar days before the date of the sterilization. A new consent form is required if 180 days have passed before the surgery is provided.

The consent for sterilization cannot be obtained while the patient is in the hospital for labor, childbirth, abortion or under the influence of alcohol or other substances that affects the patient's state of awareness.

3. The individual to be sterilized is at least twenty-one (21) years old at the time consent is obtained.
4. The individual to be sterilized is mentally competent.
5. The individual to be sterilized is not institutionalized: i.e., not involuntarily confined or detained under a civil or criminal status in a correctional or rehabilitative facility or confined in a mental hospital or other facility for the care and treatment of mental illness, whether voluntarily or involuntarily committed.
6. The individual has voluntarily given informed consent on the approved Sterilization for Medicaid beneficiaries Form, SCDHHS Form 1723.

Abortions

Abortions and services associated with the abortion procedure shall be covered only when the physician has found, and certified in writing that on the basis of his professional judgment, the pregnancy is a result of rape or incest or the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed and must be documented in the Medical Record by the attending physician stating why the abortion is necessary; or if the pregnancy is the result of an act of rape or incest. Abortions must be documented with a completed Abortion Statement Form which will satisfy federal and state regulations.

The following guidelines are to be used in reporting abortions performed on or before **September 30, 2015**.

1. Diagnosis codes in the 635 range should be used **ONLY** to report therapeutic abortions.
2. Spontaneous, inevitable or missed abortions should be reported with the appropriate other diagnosis codes (e.g., 630, 631, 632, 634, 636, and 637).
3. Abortions which are reported with diagnosis and procedure codes for therapeutic abortions must be accompanied by complete Medical Records which substantiate life endangerment to the mother or that the pregnancy is the result of rape or incest **and** with the signed abortion statement.
4. The abortion statement must contain the name and address of the patient, the reason for the abortion and the physician's signature and date. The patient's

certification statement is only required in cases of rape or incest.

The following guidelines are to be used in reporting abortions performed on or after **October 1, 2015**.

1. Diagnosis codes to be used only to report therapeutic abortions are:

Diagnosis Codes				
O04.5	O04.6	O04.7	O04.80	O04.81
O04.82	O04.83	O04.84	O04.85	O04.86
O04.87	O04.88	O04.89	Z33.2	

2. Spontaneous, inevitable or missed abortions should be reported with the appropriate other diagnosis codes

Diagnosis Codes							
O01.0	O01.1	O01.9	O02.0	O02.1	O02.81	O02.89	O02.9
O03.0	O03.1	O03.2	O03.30	O03.31	O03.32	O03.33	O03.34
O03.35	O03.36	O03.37	O03.38	O03.39	O03.4	O03.5	O03.6
O03.7	O03.80	O03.81	O03.82	O03.83	O03.84	O03.85	O03.86
O03.87	O03.88	O03.89	O03.9	O04.5	O04.6	O04.7	O04.80
O04.81	O04.82	O04.83	O04.84	O04.89	Z33.2		

3. Abortions which are reported with diagnosis and procedure codes for therapeutic abortions must be accompanied by complete Medical Records which substantiate life endangerment to the mother or that the pregnancy is the result of rape or incest **and** with the signed abortion statement.

4. The abortion statement must contain the name and address of the patient, the reason for the abortion and the physician’s signature and date. The patient’s certification statement is only required in cases of rape or incest.

Information regarding the appropriate policies and billings for hysterectomies, sterilizations, and therapeutic abortions can be found in the Physicians and Hospital Services Provider Manual. Both manuals may be found on the SCDHHS website at www.scdhhs.gov and may be updated via Medicaid bulletins.

Independent Laboratory and X-Ray Services

Benefits cover laboratory and x-ray services, including genetic testing services if medically necessary and ordered by a physician and provided by independent

laboratories and portable x-ray facilities. An independent laboratory and x-ray facility is defined as a facility licensed by the appropriate State authority and not part of a hospital, clinic, or physician's office. Several State based organizations and Providers are enrolled as independent laboratory Providers and submit claims as an independent laboratories. MCOs are responsible for reimbursement to these State based independent laboratory Providers. State based organizations include but are not limited to the Department of Alcohol & Other Drug Abuse Services and its commissions and the Department of Mental Health and its mental health centers. Both of these state entities are enrolled as and serve as independent laboratories with South Carolina Medicaid and the MCO is responsible for reimbursing the services provided by these independent lab Providers. For detailed Medicaid policies regarding independent laboratory and x-ray services please see the [Physicians, Laboratories, and Other Medical Professionals Provider Manual](#) at <https://www.scdhhs.gov> and may be updated via Medicaid bulletins.

Inpatient Hospital Services

Inpatient hospital services are those services, provided under the direction of a physician, furnished to a patient who is admitted to an acute care medical facility for a period defined in the SC Medicaid Hospital provider manual at www.scdhhs.gov. An admission occurs when the Severity of Illness/Intensity of Services criteria set forth by the reviewing MCO (approved by SCDHHS) is met. Among other services, inpatient hospital services encompass a full range of necessary diagnostic and therapeutic care including surgical, dental, medical, general nursing, radiological and rehabilitative services in emergency or non-emergency conditions. Additional inpatient hospital services would include room and board, miscellaneous hospital services, medical supplies, and equipment.

The MCO that covers a Medicaid MCO Member on the day of admission to a hospital is responsible for the facility charges associated with the entire stay (through discharge), even if the Medicaid MCO Member changes to another MCO or FFS during the hospital stay or if the member switches eligibility categories at the end of a month. In cases where the beneficiary loses Medicaid eligibility entirely (not just managed care eligibility) the MCO is no longer responsible for facility charges unless a retroactive eligibility determination re-establishes responsibility for payment. The date of service will dictate the responsible MCO for any professional charges submitted on the CMS-1500 claim form. Similarly, if the Medicaid MCO Member is enrolled with Medicaid Fee for Service (FFS) on the date of admission, FFS Medicaid is responsible for facility charges for the duration of the inpatient stay to discharge and the MCO is responsible for professional charges submitted on the CMS-1500 based on beneficiary MCO enrollment date and the service date on the professional claim.

For example, an MCO (MCO1) member is admitted to a hospital on August 20th and discharged on September 15th. On September 1, the member changes to a new MCO (MCO2). MCO1 is responsible for all facility charges from admission to discharge and all physician charges from August 20th to August 31st. MCO2 is not responsible for any facility charges but has responsibility for all physician charges from September 1st to September 15th.

Current Medicaid Service Limitations: Coverage of inpatient hospital services is limited to an acute care hospital services to include psychiatric services. Inpatient rehabilitative services provided in a separate medical rehabilitation facility or a separately licensed specialty hospital are not reimbursable. Private rehabilitative services in a separate medical rehabilitation facility are limited to children under the age of 21. Rehabilitation services which are rendered to Medicaid members on an inpatient or outpatient basis at an acute care hospital are Medicaid reimbursable services that are the responsibility of the MCO.

For additional detailed policy information regarding Inpatient hospital services please see the Hospital Services Provider Manual at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins.

Institutional Long-Term Care Facilities / Nursing Homes

MCO's are required to pay, at a minimum, for the first ninety (90) days of continuous confinement in a long-term care facility, nursing home, or hospital that provides swing bed or administrative days. Additionally, the MCO is responsible for long-term care until the Medicaid MCO Member can be disenrolled at the earliest effective date allowed by system edits, at which time payment for Institutional Long-Term Care services will be reimbursed fee-for-service by the Medicaid program. The maximum potential MCO liability is a total of 120 days.

Administrative days are counted as part of the hospital stay and **do not** count towards fulfilling the MCO long-term care responsibility.

Swing Beds are counted in the same way as nursing home days and **do** count towards fulfilling the MCO responsibility for long-term care. SCDHHS will work in conjunction with MCO Managed Care staff to ensure timely identification of persons certified to enter long-term care facilities/nursing homes.

Admission of a MCO member must follow the Medicaid requirements of participation for nursing facilities, including level of care certification, preadmission screening and resident review (PASARR), resident assessment, notification of patient's rights, and other requirements. The MCO must obtain a level of care certification (DHHS Form 185) from CLTC, the social worker, or the nursing facility for a Medicaid MCO Member upon admission to the facility. The Certification Letter will have an effective period of forty-five (45) calendar days. The MCO does not authorize nursing home placement when CLTC staff determines level of care requirements have been met, but rather works with the facility to coordinate care until the Medicaid MCO Member can be disenrolled. To determine the date of admission to a nursing facility, the MCO should request a copy of the Notice of Admission, Authorization and Change of Status for Long Term Care (DHHS Form 181) from the nursing facility.

The SCDHHS CLTC nurse consultant, in addition to the above, must complete the following tasks:

- Review the completed assessment and follow policy for assessment
- Follow policy for level of care determination
- If referral for Medicare for skilled applicant is appropriate, complete CLTC Notification and instruct support staff to send to applicant and agency, if appropriate
- Follow policy for retroactive certification, if appropriate
- Follow policy for time-limited certification, if appropriate
- Follow policy for completing Level of Care Certification Letter (DHHS Form 185) and instruct support staff to mail copies to agencies and person designated on form
- Follow policy for nursing facility under denial of payment sanctions
- Complete Nursing Home Certification

For additional detailed policy information regarding Nursing Facility services, please see the Nursing Facility Provider Manual at <https://www.scdhhs.gov/>. [Nursing Facility services](#) may be updated via Medicaid bulletins.

Maternity Services

Maternity services include high levels of quality care for pregnant Medicaid MCO Members. Maternity care service benefits include prenatal, delivery, postpartum services and nursery charges for a normal pregnancy or complications related to the pregnancy. All pregnant Medicaid MCO Members and their infants will receive risk appropriate medical and Referral Services.

Hospital claims billed on the facility claim form that include both a cesarean section and sterilization are not reimbursed through Family Planning funding sources. Therefore, all MCOs are responsible for these inpatient hospital claims.

Newborn Hearing Screenings

Newborn Hearing Screenings are included in the Core Benefits when they are rendered to Newborns in an inpatient hospital setting. This procedure is **not** included in the DRG; therefore the MCO shall work with Providers to insure payment. The MCO is responsible for payment of this screening. The MCO rate includes payment for this service.

Outpatient Pediatric Aids Clinic Services (OPAC)

An Outpatient Pediatric AIDS Clinic (OPAC) is a distinct entity that operates exclusively for the purpose of providing specialty care, consultation and counseling services for

Human Immunodeficiency Virus (HIV) infected and exposed Medicaid-eligible children and their families. Children who are born to HIV positive mothers, but do not test positive, are seen every three months in the clinic until they are two (2) years old. Those children that do test positive are seen twice a week for eight (8) weeks and then once a month until they are two (2) years old. Children who do not improve stay in the OPAC Program.

OPAC is designed to be a multidisciplinary clinic. The mission of OPAC is to follow children who have been exposed to HIV perinatal as children born to women infected with HIV. The following activities shall be considered the key aspects of OPAC and may be provided by OPAC or an alternate MCO network Provider:

- All exposed children will be followed with frequent clinical and laboratory evaluations to allow early identification of those children who are infected.
- Provide proper care for infected infants and children (*i.e.*, pneumocystis carinii prophylaxis or specific treatment for HIV infection).
- Coordinate Primary Care services with the family's Primary Care Provider (when one is available and identified).
- Coordinate required laboratory evaluations that occur when clinical evaluations are not needed. These should be arranged at local facilities if this is more convenient and the tests are available locally. May be coordinated with the Primary Care Provider and often with the assistance of local health department personnel.
- Provide management decisions and regularly see the children and parents when HIV infected children are hospitalized at the Level III Hospitals. When HIV infected children are hospitalized at regional or local hospitals with less severe illnesses, provide consultation to assist in the management of their care.
- Provide case coordination and social work services to the families to assure specialty and Primary Care follow-up and to assist in obtaining needed services for the child and family.

Outpatient Services

Outpatient services are defined as those preventive, diagnostic, therapeutic, rehabilitative, surgical, mental health, facility services for dental, and Emergency Services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding 24 hours. Outpatient/ambulatory care facilities include Hospital Outpatient Departments, Diagnostic/Treatment Centers, Ambulatory Surgical Centers, Emergency Rooms, End Stage Renal Disease Clinics (ESRD) and Outpatient Pediatric AIDS Clinics (OPAC).

Comprehensive neurodevelopment and/or psychological developmental assessment and testing services shall be provided to Eligible children under the age of 21 who have, or are suspected to have, a developmental disability, significant developmental delay, behavioral or learning disorder or other disabling condition. Such medically necessary

diagnostic services, treatment and other measures are for the purpose of correcting or ameliorating physical and/or mental illnesses and conditions which left untreated, would negatively impact the health and quality of life of the child.

For additional detailed policy information regarding Inpatient hospital services please see the Hospital Services Provider Manual at <https://www.scdhhs.gov> and may be updated via Medicaid bulletins.

Physician Services

Physician services include the full range of preventive care services, Primary Care medical services and physician specialty services, including genetic testing where medically necessary. All Services must be Medically Necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care and treatment of the specific condition. Physician services are performed at physician's offices, patients' homes, clinics, skilled nursing facilities. Technical services performed in a physician's office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service. For detailed Medicaid policies regarding physician services please see the [Physicians, Laboratories, and Other Medical Professionals Provider Manual](https://www.scdhhs.gov) at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins.

Prescription Drugs

Prescription drug coverage will be provided by the MCOs according to the Medicaid MCO Member's needs. Should a Medicaid MCO Member change plans, the new MCO is required to honor existing prescriptions needing a Prior Authorization under the new plan's formulary for a period of no less than thirty (30) days. In addition, the MCO must provide continuation of pharmaceutical services and/or honor the Prior Authorization an additional thirty (30) days, for a total of up to sixty (60) days for any drug that the member is currently taking with an FDA indication to treat one or more of the following conditions:

- Major Depression
- Schizophrenia
- Bipolar Disorder
- Major Anxiety Disorder
- Attention Deficit/Hyper Activity Disorder

MCOs are required to support the Universal PA Medication form for all medications except for the following medications.

- Synagis
- [17-P/Makena Universal Authorization Form](#) – A Universal Authorization form has been developed for the ordering and use of 17-P injections to reduce the risk of preterm birth in women with a singleton pregnancy that have a history of

singleton spontaneous preterm birth. Use of this form is required for all requests for 17-P/Makena for all Medicaid MCO beneficiaries. The 17-P/Makena form is located on the SCDHHS website at <https://msp.scdhhs.gov/managedcare/site-page/reference-tools>.

Effective for dates of service on or after July 1, 2015, medications for the treatment of Hepatitis C Virus (HCV) will be carved-out of the South Carolina Medicaid Managed Care Organization (MCO) pharmacy benefit. Beginning with dates of service on or after July 1, 2015, these medications will be provided to MCO beneficiaries through the fee-for-service (FFS) pharmacy program. HCV medications are defined as those in the following Specific Therapeutic Classes (HIC-3s), as defined by First DataBank (FDB): W0B, W0D, W5G, W5V, and W5Y.

MCOs should reject claims submitted for HCV medications with a date of service on or after July 1, 2015. Claims should reject with a supplemental message instructing the pharmacy provider to bill Hepatitis C medications to the FFS pharmacy program. Recognizing that pharmacy benefit plan parameters and capabilities may vary among MCOs, SCDHHS will allow each MCO to determine the appropriate NCPDP Error Code for claim denials. The MCO must include supplemental messaging instructing the pharmacy provider to bill the FFS pharmacy program. An example of this supplemental messaging is: *“Submit to fee-for-service Medicaid (BIN: ØØ9745).”*

Billing questions regarding the FFS point of sale pharmacy system should be directed to the Magellan Pharmacy Support Call Center at 1-866-254-1669.

Prior authorization requests for HCV medications should be directed to the Magellan Clinical Call Center at:

Phone: 1-866-247-1181

Fax: 1-888-603-7696

All MCOs must also have a Pharmacy Override Policy which allows provision of no less than a five (5) day emergency supply of all prescription drugs. Neither prior authorization, nor a call, is required for the emergency five (5) day supply. Dispensing fees may be charged on both the five (5) day supply and when the balance of the prescription is filled by the pharmacy. Co-payments are not allowed on the five (5) day emergency supply and may only be assessed when the balance of the prescription is filled. Emergency supplies will not count toward a Medicaid members prescription limits. Prescription limits will only apply when the balance of the prescription is filled. Override information for each MCO can be found at <https://msp.scdhhs.gov/>

Updates to an MCO’s formulary must be provided to Medicaid MCO beneficiaries and providers in a timely manner. The formulary must allow for coverage of any non-formulary products currently reimbursable as fee-for-service by South Carolina Medicaid. Information regarding coverage allowance for non-formulary products must be disseminated to Medicaid MCO beneficiaries and Providers.

Preventive and Rehabilitative Services for Primary Care Enhancement (PSPCE/RSPCE)

Other services, which were previously limited to high risk women, are now available through PSPCE/RSPCE to any Medicaid Beneficiary determined to have medical risk factors. Provision of PSPCE/RSPCE encompasses activities related to the medical/dental plan of care which: promote changes in behavior, improve the health status, develop healthier practices by building client and/or care giver self-sufficiency through structured, goal orientated individual/group interventions, enhance the practice of healthy behaviors, and promote the full and appropriate use of primary medical care.

The goal of PSPCE/RSPCE is maintenance/restoration of the patient at the optimal level of physical functioning. The service must include the following components:

- Assessment/evaluation of health status, patient needs, knowledge level
- Identification of relevant risk factors;
- Development/revision of a goal-orientated plan of care (in conjunction with the physician/dentist and patient through verbal or passive communication) that address needs identified in the assessment/evaluation and which specifies the service(s) necessary to maintain/restore the patient to the desired state of wellness/health;
- Anticipatory guidance/counseling to limit the development/progression of a disease/condition to achieve the goals in the medical plan of care;
- Promoting positive health outcomes;
- Monitoring of health status, patient needs, skill level, and knowledge base/readiness; and
- Counseling regarding identified risk factor(s) to achieve the goals in the medical plan of care.

PSPCE/RSPCE is not intended to be offered to all Medicaid clients. It is a service that is intended to assist physicians/dentists in accepting difficult-to-treat clients into their practice. These clients may be difficult due to their diseases.

MCOs may develop utilization review protocols for this service. Protocols must be approved by SCDHHS prior to implementation.

Psychiatric Services

MCO's are responsible for the full array of behavioral health services set forth in the Licensed Independent Practitioner Manual and the Physicians, Laboratories, and Other Medical Professionals Provider Manual at <https://www.scdhhs.gov> provided by Psychiatrists, Psychologists, Licensed Psych-educational Service Providers (qualified and performing services as Licensed Independent Practitioners), Licensed Professional Counselors, Licensed Social Workers, Licensed Marital and Family Counselors and mental health services provided in the FQHC and/or RHC setting.

Comprehensive neurodevelopment and/or psychological developmental assessment and testing services shall be provided to Eligible children under the age of 21 who have, or are suspected to have, a developmental disability, significant developmental delay, behavioral or learning disorder or other disabling condition. Such Medically Necessary diagnostic Services, treatment and other measures are for the purpose of correcting or ameliorating physical and/or mental illnesses and conditions which left untreated, would negatively impact the health and quality of life of the child. MCO's responsibility for coverage of these tests and assessments includes all settings outside of the school based setting.

Psychological testing/assessment may be used for the purpose of psycho-diagnostic clarification, as in the case of establishing a DSM diagnosis or a differential diagnosis, once a thorough comprehensive assessment/initial clinical interview has been conducted and testing is deemed necessary for further clinical understanding or treatment planning.

All psychological assessment/testing by the assessor must include a specific referral question(s) that can be reasonably answered by the proposed psychological assessment/testing tools to be administered. All requests for psychological assessment/testing must clearly establish the benefits of the psychological assessment/testing, including, but not limited to, how the psychological assessment/testing will inform treatment.

Units approved for psychological assessment/testing must be commensurate with industry standards, to include consideration of scoring and interpretation as well as potential behavioral health concerns that may complicate the administration of psychological measures and require extra time, e.g., significant developmental disorders.

All beneficiaries must be covered for psychological assessment/testing, as per the Rehabilitative Behavioral Health manual, if they have a diagnosis listed in the current version of the DSM, or if psychological assessment is used to establish a clinically necessary differential diagnosis.

Rehabilitative Therapies for Children – Non-Hospital Based

The Title XIX SC State Medicaid Plan provides for a wide range of therapeutic services available to individuals under the age 21 who have sensory impairments, mental retardation, physical disabilities, and/or developmental disabilities or delays.

Rehabilitative therapy services include: speech-language pathology, audiology, physical and occupational therapies, and Nursing Services for Children under 21 years of age. These services are provided through the Local Education Authorities (LEA) or the Private Rehabilitation Services programs. MCOs are only responsible for private providers that are not providing services under contract with LEA.

The specific services and fee-for-service limitations can be found in the Private Rehabilitative Therapy and Audiological Services Provider Manual at <https://www.scdhhs.gov> and may be updated via Medicaid bulletins.

Substance Abuse Services

Alcohol and other drug abuse treatment services provided by the Department of Alcohol and Other Drug Abuse Services (DAODAS) and its subcontracted 33 county alcohol and drug abuse authorities are part of the MCO's core benefit package. Alcohol and other drug abuse services will be covered by the MCOs according to the Medicaid MCO Member's needs the MCO is responsible for both Alcohol or Other Drug (AOD) diagnoses and/or AOD risk factors.

Factors that place individuals at risk for developing substance use problems are recognized by Substance Abuse and Mental Health Administration (SAMSHA) and National Institute of Drug Abuse (NIDA), and there is extensive research available regarding bio-psychosocial behaviors/conditions that contribute to risk. These risk factors, in conjunction with actual substance use or abuse or an environment where substances are used or abused, indicate the need to treat the individual or family.

AOD Risk Factors by domains:

Individual Early (pre-adolescent) and adult with persistent problem behaviors:

- Risk taking, high sensation seeking behaviors (in adolescents, consider developmental stages)
- Antisocial behavior
- AOD use that does not meet diagnostic criteria (in adolescents, includes experimental use; in adults, increased use when stressed or self-medicating due to other symptoms/problems)

Family:

- Low perception of harm (increases likelihood of initiating use)
- Perception of parental/sibling acceptance/approval of substance abuse (strong predictor of adolescent substance abuse; linked to alcohol initiation during family gatherings)
- Lack of mutual attachment & nurturing by parents/caregivers with a family history of alcoholism
- Chaotic home environment with substance use in home

Peers/School/Community:

- Associating with substance using peers
- Drinking in social settings or having peers who do
- Accessibility to AOD

- Availability of AOD
- Misperceptions about extent and acceptability of drug abusing behavior
- Beliefs that drug abuse is generally tolerated

Level of care is not determined by a single risk factor or severity of a specific ASAM dimension. Rather a combination of factors determines the level of risk and severity. In order to qualify for AOD services, the individual should have identified at least 2 risk factors, one of which involves active substance use in any of the three (3) domains. Risk factors should be identified and addressed throughout the assessment. Severity on ASAM dimensions should be reflected in documentation. The IPOC should be directly linked the assessment findings and the risk factors should be addressed in the goals/objectives.

MCOs and commissions will assess risk factors based on the following:

Individual:

- Stressful life experiences (including physical/sexual abuse, trauma)
- Family genetic vulnerability
- Prenatal exposure to AOD
- Parental supervision/monitoring,
- Attitudes toward substance use (individual, family, environment)
- Age at first use (the earlier use begins, the greater the likelihood of developing problems later in life)
- Early puberty (indicator of higher risk)

Family:

- Monitoring of behavior (caregiver)
- Parental support and involvement (caregiver)
- Relationships with parents, older siblings (individual)

Peers/School/Community:

- Association with substance using peers; rejection by peers; exposure to peers with problems behavior (linked to substance in same month)
- Individual's perceptions of peer, school community's attitudes and norms about substance use & problem behaviors
- Drinking in social settings or having peers who do (increases likelihood of abusing alcohol later in life)
- How individual obtains substances (parents, friends, underage parties, home) (majority of alcohol consumed by youth obtained through social sources)

- Availability of alcohol/illicit drugs (home, friends' homes, school, community)

Protective factors that may be considered in developing the IPOC:

- Developing impulse control during pre-adolescence (associated with fewer behavioral issues during adolescence)
- Delay in drinking until age 20 or 21 (decreases risk of developing severe substance related problems in adulthood)
- Active parenting style and age appropriate parental monitoring
- Strong protection, parental support & involvement (can reduce influence of other strong risks)
- Strong anti-drug norms in school and community

Medicaid members will be assessed by one of the thirty-three (33) county alcohol and drug abuse authorities and an Individual Plan of Care (IPOC) will be completed.

All MCO members requiring Level I (discrete) or Level II.1 (Intensive Outpatient Program) services through DAODAS or its subcontracted authorities will require the rendering Provider to fax a prior authorization (PA) request along with the IPOC and patient assessment. Should a PA be needed in support of a continuation of services, the rendering Provider must fax a Continued Stay Authorization form in addition to an updated IPOC when appropriate.

MCO members requiring residential detoxification (Level III.2-D, Level III.7D), partial hospitalization/day treatment (Level II.5), and/or residential treatment (Level III.5, Level III.7) through DAODAS or its subcontracted authorities will require the rendering Provider to call the MCO and request a PA for both the initial and continuation of services.

Service level agreements are in place with the MCOs to ensure a timely response from Provider requests for PA. MCOs must strive to provide a response for substance abuse services within five (5) business days to initial PA requests for Level I and Level II.5 services, MCO's maximum allowed response time for all PA requests is fourteen (14) calendar days. MCOs are to respond to PA requests for detox, residential, partial hospitalization/day treatment within twenty-four (24) hours, or no later than close of the following business day. Should a member step down to Level I or Level II.1 services, the MCO is expected to provide a temporary PA to cover Level I and Level II.1 services for a period of five (5) days, permitting the rendering Provider adequate time to fax documents as outlined above.

In addition to substance abuse services, the DAODAS commissions may also have the ability to provide non-substance abuse behavioral health services. In order to strengthen Provider network adequacy, health plans are allowed the ability to utilize the commissions for more than just substance abuse related services.

Transplant and Transplant-Related Services

Group I – Kidney and Corneal

Kidney: The MCO is responsible for notifying their SCDHHS program representative of an impending transplant case and working with the program representative to eliminate administrative confusion for the beneficiary and ensure that the member gets needed transplant services. Additionally, the MCO is responsible for all services prior to seventy-two (72) hours pre-admission, post-transplant services upon discharge, and post-transplant pharmacy services.

All potential kidney transplants, cadaver or living donor, must be authorized by the SCDHHS-contracted Quality Improvement Organization (QIO) before the services are performed. The QIO will review all Medicaid referrals for organ transplants and issue an approval or a denial.

Corneal: MCO is responsible for this service.

Group II – Bone Marrow (Autologous Inpatient and Outpatient, Allogenic Related and Unrelated, Cord, and Mismatched), Pancreas, Heart, Liver, Liver with Small Bowel, Liver/Pancreas, Liver/Kidney, Kidney/Pancreas, Lung and Heart/Lung, Multivisceral, Small Bowel

For in-state evaluations and transplants the MCO medical director will make a medical necessity determination and forward any approved requests to KePRO, fax number 855-300-0082 or <http://scdhhs.kepro.com/>. Unapproved requests for in-state transplant evaluations remain the responsibility of the MCO.

For out of state evaluations and transplants the MCO's medical director will make a medical necessity determination and determine if it should be approved. If approved the MCO medical director shall contact the Department's medical director to obtain approval of the medical necessity for both the evaluation and the transplant. Upon approval by the Department's medical director the MCO shall submit the request along with the written approval issued by the Department's medical director to KePRO for issuance of a prior authorization request. This request is an operational requirement to ensure the transplant claim is paid appropriately by healthy connections. Additionally, the MCO is responsible for all services prior to seventy-two (72) hours pre-admission, post-transplant services upon discharge, and post-transplant pharmacy services.

All potential Group II transplants, cadaver or living donor, except for matched bone marrow (autologous inpatient and outpatient, allogeneic related and unrelated and cord), must be authorized by the QIO before the services are performed. The Department will review all Medicaid referrals for organ transplants and issue an approval or a denial.

If the transplant is approved, the approval letter serves as authorization for pre-transplant services (seventy-two [72] hours preadmission), the event (hospital

admission through discharge), and post-transplant services up to ninety (90) days from the date of discharge.

Vision Care Services

All vision services for Medicaid MCO Members under age 21 and some limited benefits for adults over age 21 that are described in the SCDHHS Physicians, Laboratories, and Other Medical Professionals Provider Manual, are the responsibility of the MCO, including any necessary hardware to correct vision issues of Medicaid MCO members. MCOs are responsible for one (1) vision test during any rolling twelve (12) month period, as well as the other vision services outlined in the SCDHHS Physicians, Laboratories, and Other Medical Professionals Provider Manual at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins.

For all cites in Section 4.1.3 through Section 4.1.6, please refer to the contract for all requirements between MCO and SCDHHS.

4.2 Service Limits

For all cites in Section 4.2, please refer to the contract for all requirements between MCO and SCDHHS.

4.3 Out of Network Coverage

For all cites in Section 4.3, please refer to the contract for all requirements between MCO and SCDHHS.

4.4 Second Opinions

For all cites in Section 4.4, please refer to the contract for all requirements between MCO and SCDHHS.

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

For all cites in Section 4.5, please refer to the contract and the service list reflected under the Core Benefits table in this guide for all requirements between MCO and SCDHHS.

4.6 Emergency Medical Services

For all cites in Section 4.6, please refer to the contract for all requirements between MCO and SCDHHS.

4.7 Pharmacy / Prescription Drugs

For all cites in Section 4.7.1 through Section 4.7.7.12.3, please refer to the defined core services listed above and the contract for all requirements between MCO and SCDHHS.

Section 4.7.7.13 through Section 4.7.7.15: Please refer to the contract for all requirements between MCO and SCDHHS.

For all cites in Section 4.7.7.16 through Section 4.7.7.17, please refer to the contract for all requirements between MCO and SCDHHS.

4.8 Hysterectomies

For all cites in Section 4.8, please refer to the defined core services listed above and the contract for all requirements between MCO and SCDHHS.

4.9 Sterilization

For all cites in Section 4.9, please refer to the defined core services listed above and the contract for all requirements between MCO and SCDHHS.

4.10 Limitations of Abortions

For all cites in Section 4.10, please refer to the defined core services listed above and the contract for all requirements between MCO and SCDHHS.

4.11 Medical Services for Special Populations

For all cites in Section 4.11.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 4.11.2: SCDHHS is evaluating the necessity of this particular section.

For all cites in Section 4.11.3, please refer to the contract for all requirements between MCO and SCDHHS.

4.12 Targeted Case Management (TCM) Services

For all cites in Section 4.12, please refer to the contract for all requirements between MCO and SCDHHS.

4.13 School-Based Services

For all cites in Section 4.13.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 4.13.2: The MCO is not responsible for services provided by school-based Providers. The MCO shall produce the written procedures for coordination of care at the request of SCDHHS.

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

For all cites in Section 4.14, please refer to the defined Core Services listed above and the contract for all requirements between MCO and SCDHHS.

4.15 Behavioral Health Services

Section 4.15.1.1: Please refer to the Core Service of Inpatient Hospital above.

Section 4.15.1.2: Mental health services authorized or provided by a state agency are reimbursed by Medicaid fee-for-service. The MCO shall coordinate the referral of Medicaid MCO Members for services that are outside of the required Core Benefits and which will continue to be provided by enrolled Medicaid Providers. These services include, but are not limited to, Targeted Case Management services, intensive family treatment services, therapeutic day services for children, out-of-home therapeutic placement services for children, inpatient psychiatric hospital and residential treatment facility services.

For all cites in Section 4.15.1.3, please refer to the contract for all requirements between MCO and SCDHHS.

4.16 Communicable Disease Services

For all cites in Section 4.16, please refer to the defined core services listed above and the contract for all requirements between MCO and SCDHHS.

4.17 Member Incentives

Section 4.17.1 through Section 4.17.8: Incentives are for enrolled members of the MCO. In order to receive an incentive, members must complete a qualifying healthy behavior. Qualifying healthy behaviors include, but are not limited to, doctor visits, health screenings, immunizations, etc. Upon completion and verification by the MCO, members may receive incentives.

Incentive items cannot have a value of more than \$25.00 unless a greater amount is approved by the Department. Incentives may not include cash, alcohol, tobacco, ammunition, weapons or gift cards that may be used to purchase the aforementioned items.

MCOS's are not required to submit member incentive requests to SCDHHS for incentive items meeting the requirements outlined above where the amount is \$25 or less per qualifying behavior. Incentive items costing more than \$25 must be submitted to SCDHHS for review using the *Member Incentive Form* located in the MCO Report Companion Guide.

No offers of material or financial gain, other than Core Benefits expressed in the MCO contract, may be made to any Medicaid Beneficiary as incentive to enroll or remain enrolled with the MCO. This includes, but is not limited to, cash, vouchers, gift certificates, insurance Policies, or other incentive.

4.18 Additional Services

For all cites in Section 4.18.1 through Section 4.18.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 4.18.4 through Section 4.18.5: If the MCO decides it would like to implement additional services to change and/or improve health among its membership the MCO must submit the following information to SCDHHS for review. The submission to SCDHHS must include the MCO's name, the name and a description of the MCO request, cost, the background and rationale behind the request, the objective of the request, the report(s) that will be produced after implementation, the duration of the additional service, the comparative data being utilized to determine the success/failure of the service, the population being targeted and the additional service discontinuation criteria.

No offers of material or financial gain may be made to any Medicaid Beneficiary as incentive to enroll or remain enrolled with the MCO. This includes, but is not limited to, cash, vouchers, gift certificates, insurance Policies, or other incentive. The MCO can only use, in Marketing Materials and activities, any benefit or service that is clearly specified under the terms of the contract, and available to Medicaid MCO Members for the full contract period which has been approved by SCDHHS. Additional benefits that have been approved by SCDHHS may be used in Marketing Materials and activities. These benefits include, but are not limited to: reduced or no copayments, medications, Additional Services and visits, vision and dental benefits to adults, increases over Medicaid limitations or membership in clubs and activities.

Section 4.18.6: SCDHHS currently has a Health Plan Comparison Guide for Medicaid members on the South Carolina Healthy Connections Choices (SCHCC) website. This guide is utilized by members to make an informed choice when selecting an MCO to provide healthcare. The health plans have the opportunity to make changes to the Health Plan Comparison Guide on a bi-annual basis. Any informational changes the MCO plan would like the Enrollment Broker to make must be submitted to SCDHHS by October 15th for insertion into the Enrollment Broker's materials for January. Any informational changes submitted to SCDHHS after October 15th and before May 15th will take affect with the Enrollment Broker in July. Extenuating circumstances, including service level changes to the Medicaid program may necessitate SCDHHS updating the enrollment broker information outside of this schedule. SCDHHS retains sole discretion of when it will update enrollment broker information outside of the schedule above. If SCDHHS needs to update the Comparison Guide outside of the schedule, the health plans will have the opportunity to have changes made at that time.

For all cites in Section 4.18.7 through Section 4.18.8, please refer to the contract for all requirements between MCO and SCDHHS.

4.19 Excluded Services

The services detailed below are those services which continue to be provided and reimbursed by the current Medicaid program and are consistent with the outline and definition of covered services in the Title XIX SC State Medicaid Plan. Payment for these services will remain fee-for-service. MCOs are expected to be responsible for the Continuity of Care for all Medicaid MCO Members by ensuring appropriate referrals and linkages are made for the Medicaid MCO Member to the Medicaid fee-for-service Provider.

Autism Spectrum Disorder Services

Autism spectrum services provided by Early Intensive Behavioral Interventionists (EIBI) are services outside the managed care capitation rate and reimbursed Medicaid fee-for-service. The MCO shall coordinate the referral of Medicaid MCO Members for these services. The diagnosis of Autism does not relinquish the MCO of responsibility for the member.

The MCO continues to retain responsibility for any other medical and psychological/psychiatric services that children diagnosed with Autism Spectrum Disorder may require that are currently part of the managed care coverage array. Examples of services that may be necessary for children with an Autism Spectrum Disorder include, but are not limited to, Autism testing by mental health professionals, Speech and Language therapy, and physician visits and treatment.

Mental Health Authorized or Provided by State Agencies

Mental health services authorized or provided by a state agency are reimbursed by Medicaid fee-for-service. The MCO shall coordinate the referral of Medicaid MCO 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 Title XIX SC State Medicaid Plan. These services include, but are not limited to, Targeted Case Management services, intensive family treatment services, therapeutic day services for children, out-of-home therapeutic placement services for children, inpatient psychiatric hospital and residential treatment facility services.

Medical (Non-Ambulance) Transportation

Medical non-ambulance transportation is defined as transportation of the beneficiary to or from a Medicaid covered service to receive medically necessary care. This transportation is only available to eligible beneficiaries who cannot obtain transportation on their own through other available means, such as family, friends or community

resources. The MCO should assist the Medicaid MCO beneficiary in obtaining medical transportation services through the SCDHHS Enrollment broker system as part of its Care Coordination responsibilities, as detailed below. See Appendix 3 for Enrollment broker contact information.

Broker-Based Transportation (Routine Non-Emergency Medical Transportation)

These are transports of Medicaid MCO beneficiaries to covered services as follows:

- Urgent transportation for Medicaid MCO beneficiary trips and urgent transportation for follow-up medical care when directed by a medical professional
- Unplanned or unscheduled requests for immediate transportation to a medical service when directed by a medical professional (*i.e.*, pharmacy, hospital discharge)
- Routine non-Emergency transportation to medical appointments for eligible Medicaid MCO beneficiaries (Any planned and/or scheduled transportation needs for Medicaid beneficiaries must be prearranged via direct contact with the regional brokers)
- Non-Emergency transports requiring BLS that are planned/scheduled transports to a scheduled medical appointment (*i.e.*, transport from nursing home to physician's office, nursing home to dialysis center or hospital to residence)
- Non-Emergency wheelchair transports that require use of a lift vehicle and do not require the assistance of medical personnel on board at the time of transport to medical appointments for Eligible Beneficiaries (These transports do not require the use of an ambulance vehicle.)

MCO staff should communicate directly with the transportation broker to ensure services are arranged, scheduled, and fulfilled as required for a Medicaid MCO beneficiary's access to Medicaid-covered services. These services are paid fee-for-service.

Dental Services

Routine and emergency dental services are available to Medicaid MCO Members under the age of 21. Limited dental services are available to Medicaid MCO beneficiaries age 21 and over. The dental program for all Medicaid MCO beneficiaries is administered by the SCDHHS dental broker and is not included as the responsibility of the MCO. As described above in the covered services section of the P&P facility charge for dental services provided in ambulatory surgical centers and operating rooms remain the responsibility of the MCO. The dental broker is responsible for the determination of medical necessity for the use of such facilities and the MCO's must comply with their determination and pay facility fees for such services. It is the facilities responsibility to furnish the authorization to the MCO.

Targeted Case Management (TCM) Services

Targeted Case Management (TCM) consists of services which will assist an individual eligible under the State plan in gaining access to needed medical, social, educational, and other services. A systematic referral process to Providers for medical education, legal and rehabilitation services with documented follow-up must be included. TCM services ensure the necessary services are available and accessed for each Eligible patient. TCM services are offered 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 a head or spinal cord injury or a related disability, children and adults with sickle cell disease and adults in need of protective services. Medicaid reimbursable TCM programs available to Beneficiaries are administered by the following:

- Department of Mental Health: Services for chronically, mentally ill adults and children with serious emotional disturbances
- Department of Alcohol and Other Drug Abuse Services: Services for substance abusers and/or dependents
- Department of Juvenile Justice: Services for children ages 0 to 21 years receiving community services (non-institutional level) in association with the juvenile justice system.
- Department of Social Services: a) Services to emotionally disturbed children ages 0 to 21 years in the custody of DSS and placed in foster care, and adults 18 years old and over in need of protective services and b) vulnerable adults in need of protective custody.
- Continuum of Care for Emotionally Disturbed Children: Children ages 0 to 21 years who are severely and emotionally disturbed.
- Department of Disabilities and Special Needs: Services to individuals with mental retardation, developmental disabilities, and head and spinal cord injuries. (Additional services available under fee-for-service include Early Intervention Care Coordination and Family Training.)
- South Carolina School for the Deaf and the Blind: Services to persons with sensory impairments. [Additional services available under fee-for-service include Early Intervention Care Coordination and Family Training for children up to age six (6).
- Sickle Cell Foundations and other authorized Providers: Services for children and adults with sickle cell disease and/or traits that enable Beneficiaries to have timely access to a full array of needed community services and programs that can best meet their needs.
- The Medical University of South Carolina: Services to children and adults with sickle cell disease

Home- and Community-Based Waiver Services

Home- and community-based waiver services target persons with long-term care needs and provide beneficiaries access to services that enable them to remain at home rather than in an institutional setting. An array of home- and community-based services provides enhanced coordination in the delivery of medical care for long-term care populations. Waivers currently exist for the following special needs populations:

- Persons with HIV/AIDS
- Persons who are elderly or disabled
- Persons with mental retardation or related disabilities
- Persons who are dependent upon mechanical ventilation
- Persons with pervasive developmental disorders
- Persons enrolled in the Medically Complex Children's waiver
- Persons who are head or spinal cord injured

Home- and community-based waiver beneficiaries must meet all medical and financial eligibility requirements for the program in which they are enrolled. A plan of care is developed by a case manager for all enrolled waiver beneficiaries and the services to be provided.

Healthy Connections Checkup (Family Planning Only Eligible Beneficiaries)

Men and Women at or below 194% of federal poverty level qualify for a limited benefit program known as Healthy Connections Checkup (Family Planning Services). This limited benefit program includes an array of Family Planning and preventative services to help prevent unintended or unplanned pregnancies and maintain the beneficiary's health. Healthy Connections Checkup/Family Planning Services include examinations, assessments, diagnostic procedures, health education and counseling services. These services may be rendered by physicians, hospitals, clinics, and pharmacies. For detailed Medicaid policies regarding the Healthy Connections Checkup program please see the [Physicians, Laboratories, and Other Medical Professionals Provider Manual](#) at <https://www.scdhhs.gov/> information may be updated via Medicaid bulletins.

Pregnancy Prevention Services – Targeted Populations

The Medicaid program provides reimbursement for pregnancy prevention services for targeted populations through state and community Providers. The Medicaid program will reimburse fee-for-service directly to enrolled Medicaid Providers for these services. The MCO should ensure that Medicaid MCO beneficiaries continue to have access to these programs.

MAPPS Family Planning Services

Medicaid Adolescent Pregnancy Prevention Services (MAPPS) provide Medicaid funded Family Planning Services to at-risk youths. MAPPS are designed to prevent teenage pregnancy among at risk youths, promote abstinence, and educate youth to make responsible decisions about sexual activity (including postponement of sexual activity or the use of effective contraception). Services provided through this program are:

- Assessments
- Service Plan
- Counseling
- Education

These services are provided in schools, office setting, homes, and other approved settings. These services will be paid for by the Medicaid fee-for-service program.

Developmental Evaluation Services (DECs)

Developmental Evaluation Services (DECs) are defined as Medically Necessary comprehensive neurodevelopment and psychological developmental, evaluation and treatment Services for Beneficiaries between the ages of 0 to 21 years. These individuals have or are suspected of having a developmental delay, behavioral or learning disability, or other disabling condition. These services are for the purpose of facilitating correction or amelioration of physical, emotional and/or mental illnesses, and other conditions, which if left untreated, would negatively impact the health and quality of life of the beneficiary. DECs are provided by one of the three tertiary level facilities located within the Departments of Pediatrics at the Greenville Hospital System, Greenville, SC; The University of South Carolina School of Medicine, Columbia, SC; or the Medical University of South Carolina a Charleston, SC. Pediatric day treatment, when rendered by DECs, is considered as one of the DEC treatment services. These services will be paid for by the Medicaid fee for service program.

4.20 Medical Necessity Determination

For all cites in Section 4.20, please refer to the contract for all requirements between MCO and SCDHHS.

4.21 Moral and Religious Objection

For all cites in Section 4.21, please refer to the contract for all requirements between MCO and SCDHHS

5.0 Care Coordination

5.1 Care Management

For all cites in Section 5.1.1 through Section 5.1.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 5.1.3: As specific risk assessment tools are created for special populations, SCDHHS will update this guide to account for the changes.

For all cites in Section 5.1.4 through 5.1.4.5, please refer to the contract for all requirements between MCO and SCDHHS.

Section 5.1.5: The MCO must submit a monthly report of all beneficiaries that are receiving care management services. The MCO must submit this report to its SharePoint monthly library by the 15th of each month. The submitted report must include the methodology for risk stratification (i.e., CRG or internal, if internal please describe and identify), the risk score, risk level (low, moderate or high), members Medicaid ID, name last and first, type of care management received by the beneficiary (i.e., home visit, phone call, other, etc.) start and end dates for inclusion in the risk category. A template of the report is available in the report companion guide.

Section 5.1.6: SCDHHS evaluating the necessity of this particular section.

5.2 Transition of Care

For all cites in Section 5.2.1. through 5.2.1.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 5.2.1.3: There may be cases where a non-participating pediatrician provides services to a newborn due to institutional and/or business relationships. Examples include post-delivery treatment prior to discharge by a pediatrician who is under contract with a hospital, as well as in-office services rendered by Non-Contracted Providers within the first sixty (60) days following hospital discharge.

In the interest of Continuity of Care, MCOs are to compensate these non-participating Providers, at a minimum, the Medicaid fee-for-service rate on the date(s) of service until such time the infant can be served by a participating physician, or can be transferred to a health plan in which the pediatrician is enrolled. A Universal Newborn Prior Authorization (PA) form has been developed and implemented as a means of facilitating the PA process for services rendered in an office setting within sixty (60) days following hospital discharge. This form is located on the SCDHHS website at <https://msp.scdhhs.gov/managedcare/site-page/reference-tools>.

For all cites in Section 5.2.1.4 through 5.2.1.8, please refer to the contract for all requirements between MCO and SCDHHS.

Section 5.2.1.9 through 5.2.1.10: The MCO that covers a Medicaid MCO Member on the day of admission to a hospital is responsible for the facility charges associated with

the entire stay (through discharge), even if the Medicaid MCO Member changes to another MCO or FFS during the hospital stay or if the member switches eligibility categories at the end of a month. In cases where the beneficiary loses Medicaid eligibility entirely (not just managed care eligibility) the MCO is no longer responsible for facility charges unless a retroactive eligibility determination re-establishes responsibility for payment. The date of service will dictate the responsible MCO for any professional charges submitted on the CMS-1500 claim form. Similarly, if the Medicaid MCO Member is enrolled with Medicaid Fee for Service (FFS) on the date of admission, FFS Medicaid is responsible for facility charges for the duration of the inpatient stay to discharge and the MCO is responsible for professional charges submitted on the CMS-1500 based on beneficiary MCO enrollment date and the service date on the professional claim.

For example, an MCO (MCO1) member is admitted to a hospital on August 20th and discharged on September 15th. On September 1, the member changes to a new MCO (MCO2). MCO1 is responsible for all facility charges from admission to discharge and all physician charges from August 20th to August 31st. MCO2 is not responsible for any facility charges but has responsibility for all physician charges from September 1st to September 15th.

For all cites in Section 5.2.1.11 through 5.2.2.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 5.2.2.4: Additional requirements to be determined at a later date.

Section 5.2.3: The MCO is expected to utilize their interagency liaison unless they specify other personnel for this task. The MCO will notify their program representative at SCDHHS.

For sections 5.2.4 through 5.2.7, please refer to the contract for all requirements between MCO and SCDHHS.

5.3 Continuity of Care

For sections 5.3.1 through 5.3.4.5, please refer to the contract for all requirements between MCO and SCDHHS.

5.4 Coordination of Referral(s) Outside of Core Benefits

For all cites in Section 5.4, please refer to the contract for all requirements between MCO and SCDHHS.

5.5 Health Homes and Care Coordination

For all cites in Section 5.5, please refer to the contract for all requirements between MCO and SCDHHS.

6.0 Networks (Provider Network Requirements)

6.1 General Requirements (Provider Network Adequacy Determination Process)

For all cites in Section 6.1.1 through 6.1.1.4, please refer to the contract for all requirements between MCO and SCDHHS.

Section 6.1.1.5: For county based submissions the Geocoding standards are:

1. Primary Care Physicians: For Providers acting in the capacity of a primary care physician the standard is 90% of the Managed Care eligible population in the county must have access to at least one (1) PCP within thirty (30) miles and within forty-five (45) minutes or less driving time.
2. Required Specialists: For Providers acting as specialists the standard is 90% of the Managed Care eligible population in the county must have access to the required specialist within fifty (50) miles and within seventy (75) minutes or less driving time.
3. OB/GYN: OB's acting as a primary care physician should be included in the PCP section of the Geocoding report. Also include all OB/GYN's in the specialty section of the Geocoding report.
4. FQHC/RHC: For FQHC's and RHC's Providers acting as PCP include them in the PCP section of the Geocoding report. FQHC's and RHC's acting as specialists include them in the appropriate required specialty Geocoding report.
5. Hospitals: For hospitals the standard is 90% of the Managed Care eligible population in the county must have access to a hospital within fifty (50) miles and within seventy (75) minutes or less driving time.

The geocoded solution should include only required Providers (i.e. those with a status of 1 in Table 6.1 in the contract). All PCP's are to be reported in a single combined report and all specialists are to be included in separate reports for each specialty. Geocoded reports must be uploaded to the MCO's SharePoint Required Submissions library according to the contract in section 6.2.3.

For all cites in Section 6.1.6 through 6.1.1.9, please refer to the contract for all requirements between MCO and SCDHHS.

Section 6.1.1.10: The MCO will develop and maintain written credentialing policies and procedures regarding the initial credentialing and recredentialing processes for all Providers required to be credentialed by NCQA and any other Providers required by SCDHHS. Any changes to the MCOs credentialing or recredentialing policies and procedures must be submitted to SCDHHS for approval prior to implementing the changes.

An initial onsite review by the MCO is required of all Primary Care Physicians and OB/GYN physicians acting as Primary Care Physicians, prior to the completion of the

initial credentialing process. The MCO must assess the quality, safety, and accessibility of all office sites (including part-time or satellite offices) where care is delivered. MCO staff conducting the on-site review must be trained and qualified to perform the review(s). The MCO is required to send SCDHHS training policies and personnel qualifications for staff conducting on-site reviews.

The following, at a minimum, must be included in the assessment:

- Physical/handicapped accessibility, well-lit waiting room, adequate seating
- Physical appearance that is safe and sanitary
- Adequate waiting rooms and public bathrooms
- Adequate examination rooms to include size and appearance
- Posting of office hours
- Availability of appointments
- Adequate patient record-keeping system which is compliant with state and federal requirements including, but not limited to, a secure and confidential filing system, legible file markers, and a process for quickly locating records

Additional onsite review is required within forty-five (45) calendar days when a complaint has been lodged against a specific Provider which relates to the assessment issues listed above. Should the complaint be verified, the MCO and Provider must institute actions to correct the deficiency (ies). The MCO must evaluate the effectiveness of corrective actions and certify the deficiency (ies) has been rectified.

MCO Credentialing Committee and the Credentialing Process

Each MCO will maintain a Credentialing Committee. The MCO's Medical Director shall have overall responsibility for the committee's activities. The committee shall have a broad representation from all disciplines (including mid-level practitioners) and reflect a peer review process.

Credentialing must be completed and approved by the MCO credentialing committee for all Medicaid Provider(s) who participate with the MCO prior to serving Medicaid MCO beneficiaries. All MCO Providers that have been credentialed as Medicaid MCO contracted Providers must be enrolled with SCDHHS. SCDHHS does not consider the Provider to be a Medicaid MCO Provider if they are not enrolled with SCDHHS. The MCO will be assessed a penalty as outlined in the MCO Contract if they utilize a contracted Provider not enrolled with SCDHHS. The MCO will not be able to recoup any payments made to an incorrectly contracted and credentialed Provider.

The initial credentialing and recredentialing process will include, at a minimum, the following:

- Current valid license/actions

- Current DEA and/or CDS certificate/actions
- Education/Training/Board Certification(s)
- Work History (5 years)/Justifications for Gaps
- Professional Liability/Claims History (5 years)
- Hospital Privileges/Coverage Plan
- Sanctions by Medicare/Medicaid (5 years)
- Ownership Disclosure
- National Practitioner Databank (NPDB), Health Integrity and Protection Databank (HIPDB), State Board of Examiners (for the specific discipline)
- Disclosure by Practitioner:
 - Physical and/or mental stability
 - Lack of present illegal chemical and/or substance abuse
 - History of loss of license or felony convictions
 - History of loss or limitations of privileges
 - Attestation: Correctness and completeness of application

The Provider has a right to review information submitted to support the credentialing application, to correct erroneous information, receive status of the credentialing (recredentialing) application, and to a non-discriminatory review and receive notification of these rights. The Provider has a right to appeal recredentialing adverse results (for results other than quality of care), but not at initial credentialing.

The MCO may delegate the credentialing and/or recredentialing process with SCDHHS's prior written approval. SCDHHS does not accept a Memorandum of Understanding (MOU), Letter of Agreement (LOA), the NCQA or Providers' use of the term "provisional credentialing," or any other type of agreement other than a signed (executed) contract.

MCOs are held accountable for ensuring delegated entities follow the requirements as set forth in the MCO's Policies which are based on the guidelines as outlined by SCDHHS.

MCOs must conduct an initial on-site review of all Primary Care Physicians and OB/GYN Physicians acting as Primary Care Physicians.

MCOs must meet the NCQA requirements of delegated credentialing annually. Re-credentialing for delegated entities will be completed no less than every three (3) years.

The MCO may not allow the delegated entity to then sub-delegate any portion of their delegated credentialing activities without prior written approval from SCDHHS. In

support of SCDHHS approval, the sub-delegated entity may be credentialed by a nationally recognized quality organization and confirmed by SCDHHS. Copies of the national organization's accreditation must be provided to SCDHHS.

The above guidelines apply to all services to include core and additional services as offered by the MCO.

Whether the MCO does the initial credentialing/recredentialing, or it has delegated this function to another contracted delegated entity, the MCO shall have an ongoing active monitoring program of all its Providers who participate in Medicaid through a contract with the MCO. The monitoring program must have policies and procedures in place to monitor Provider sanctions, complaints, and quality issues between credentialing cycles, and must take the appropriate action against Providers when it identifies any of the above listed occurrences. Any type Provider who is denied credentialing or recredentialing, regardless of the reason(s), must be reported to the MCO's account manager. Such notification shall be made within 1 business day and must include the primary reason for the credentialing denial. The SCDHHS account manager shall do the following:

1. Verify the active status of the Provider in MMIS
2. Report loss of credentialing to program integrity
3. Ensure continuing network adequacy with loss of Provider

Medical service Providers must meet certification and licensing requirements for the State of South Carolina. A Provider cannot be enrolled if their name appears on the Centers for Medicare and Medicaid Services (CMS) Sanction Report, or is not in good standing with their licensing board (i.e., license has been suspended or revoked). Enrolled Providers must be terminated upon notification of a suspension, disbarment, or termination by USHHS, Office of Inspector General.

An MCO is responsible for insuring all persons, whether they are employees, agents, Subcontractors, or anyone acting on behalf of the MCO, are properly licensed under applicable South Carolina laws and/or regulations. The MCO shall take appropriate action to terminate any employee, agent, Subcontractor, or anyone acting on behalf of the MCO, who has failed to meet licensing or relicensing requirements and/or who has been suspended, disbarred, or terminated. All healthcare professionals and healthcare facilities used in the delivery of benefits by or through the MCO shall be currently licensed to practice or operate in South Carolina as required and defined by the standards listed below.

- All Providers billing laboratory procedures must have a Clinical Laboratory Improvement Amendment (CLIA) Certificate. Only services consistent with their type of CLIA certification may be provided.
- Inpatient/Outpatient hospital Providers must be surveyed and licensed by the Department of Health and Environmental Control (DHEC) and certified by CMS.

- Ambulatory surgical centers must be surveyed and licensed by the Department of Health and Environmental Control (DHEC) and certified by CMS.
- End stage renal disease clinics must be surveyed and licensed by DHEC, and certified by the CMS.
- Laboratory testing facilities providing services must have a CLIA Certificate of Waiver, or a Certificate of Registration with a CLIA identification number per federal regulations. Laboratories can only provide services consistent with their type of CLIA certification.
- Infusion Centers have no licensing or certification requirements.
- Medical professionals to include, but not limited to physicians, physician's assistants, certified nurse midwives/ licensed midwives, certified registered nurse anesthetists (CRNAs)/ anesthesiologist assistants (AAs), nurse practitioners/ clinical nurse specialists, podiatrists, chiropractors, private therapists and audiologists must all be licensed and certified to practice by the appropriate Board/ Licensing body (i.e., Board of Medical Examiners, Board of Nursing, Council on Certification of Nurse Anesthetists, Board of Podiatry Examiners, Board of Chiropractic Examiners, Board of Occupational Therapy, Board of Physical Therapy, Board of Examiners in Speech Language Pathology and Audiology).
- Federally Qualified Health Clinics (FQHCs) must have a Notice of Grant Award under 319, 330 or 340 of the Public Health Services Act and be certified by CMS. FQHCs billing laboratory procedures must have a CLIA certificate.
- Rural Health Clinics (RHCs) must be surveyed and licensed by DHEC and certified by CMS. RHCs billing laboratory procedures must have a CLIA Certificate. Laboratories can only provide services that are consistent with their type of CLIA certification.
- Alcohol and Substance Abuse clinics are required to be licensed by DHEC.
- Mental health clinics must be a Department of Mental Health (DMH) sanctioned Community Mental Health Center. Out-of-state Providers must furnish proof of Medicaid participation in the State in which they are located.
- Portable x-ray Providers must be surveyed by DHEC and certified by CMS.
- Stationary x-ray equipment must be registered with DHEC.
- Mobile ultrasounds require no license or certification.
- Physiology lab Providers must be enrolled with Medicare.
- Mammography service facilities providing screening and diagnostic mammography services must be certified by the USDHHS, Public Health Services, Food and Drug Administration (FDA).
- Mail order pharmacy Providers must be licensed by the appropriate state board. Additionally, a special non-resident South Carolina Permit Number is required for

all out-of-state Providers. Such permits are issued by the Board of Pharmacy, under the South Carolina Department of Labor, Licensing and Regulations.

- Ambulance transportation service Providers must be licensed by DHEC.
- Home health service Providers must be surveyed and licensed by DHEC and certified by CMS.
- Long-term care facilities/nursing homes must be surveyed and licensed under State law and certified as meeting the Medicaid and Medicare requirements of participation by DHEC.
- For all state agencies and organizations, including The Department of Alcohol and Other Drug Abuse, The South Carolina Department of Mental Health, The Department of Social Services, The Department of Health and Environmental Control, and The Department of Disabilities and Special Needs, the MCO will credential the state agency/organization, because they are the provider of record. The state agency/organization is responsible for screening and exclusions for any employees utilized for service provision.

Requirements for the Utilization of Nurse Practitioners (NPs) as Providers of Health Care Services

Medicaid MCOs may utilize NPs to provide health care services under the following conditions:

1. Ensure NPs are able to perform the health care services allowed within the parameters of the SC Nurse Practice Act (State statute Section 40-33).

MCOs must:

- Validate NP status
 - Confirm the NPs ability to provide the allowed services as evidenced by written protocols
 - Verify there is a process in place to accommodate medically necessary hospital admissions
2. Supervising physicians (preceptors) for practices staffed only by NPs must also be enrolled in the MCO's network and must have an active license.

MCOs must:

- Authenticate the formal relationship between the NP and supervising physician (i.e., preceptor)
- Contract with any off-site supervising physician who is not already enrolled in the plan's network.

Note: If the supervising physician will not enroll, the NP-only practice cannot be enrolled into or, if already enrolled, cannot remain in the MCO's network.

3. Members shall not be automatically assigned to a NP; however, members may choose a NP to provide the health care services allowed with their scope of services.

NPs submitted on Provider files to the enrollment broker must be coded to allow member choice only

For all cites in Section 6.1.1.11 through 6.1.1.13.1, please refer to the contract for all requirements between MCO and SCDHHS.

6.2 Provider Network

Section 6.2.1: Medicaid-enrolled MCOs are responsible for providing all core services specified in the contract between SCDHHS and the MCO. The MCO may provide the services directly, enter into Subcontracts with Providers who will render services to members in exchange for payment by the MCO, or enter into other short-term agreements for services which require an attestation. Subcontracts are required with all Providers of service unless otherwise approved by SCDHHS. SCDHHS will not accept Letters of Agreements (LOA), Memorandum of Understanding (MOU), or any variations of these types of agreements.

The MCO and its network Providers and/or Subcontractors shall ensure access to healthcare services in accordance with the Medicaid contract. The MCO should also take into account prevailing medical community standards in the provision of services under the Contract. For example, the MCO or its Pharmacy Benefits Manager (PBM) is encouraged to contract with any Medicaid-enrolled DME Provider (using the appropriate NDC or UPC for billing purposes), for the provision of durable medical equipment and supplies, including diabetic testing strips and meters. However, the MCO may choose to limit the availability of these services through their PBM. A number of Medicaid Beneficiaries receive their durable medical equipment and supplies through mail delivery. MCOs are also encouraged to contract with DME Providers that provide durable medical equipment and supplies via mail order.

Such factors as distance traveled, waiting time, length of time to obtain an appointment, after-hours care must meet established guidelines. The MCO shall provide available, accessible and adequate numbers of facilities, service locations, service sites, professional, allied and paramedical personnel for the provision of core services, including all emergency services, on a 24 hour a day, 7-days-a-week basis. Provider network requirements are listed in the contract between the MCO and SCDHHS.

Sections 6.2.2.1 through 6.2.2.4.1: The following guidelines are used in the review and approval of an MCO's Provider networks. Any changes (terminations/additions) to an MCO's network in any county are evaluated by SCDHHS using the same criteria.

The MCO submits its network listing for a specific county to the Department of Health Services, requesting approval to commence Medicaid MCO Member Enrollment in that county. This county network should be submitted to the MCO's Required Submissions SharePoint site. For county based submissions the Geocoding standards are:

1. Primary Care Physicians: For Providers acting in the capacity of a primary care physician the standard is 90% of the Managed Care eligible population in the county must have access to at least 1 PCP within thirty (30) miles and within forty-five (45) minutes or less driving time.
2. Required Specialists: For Providers acting as specialists the standard is 90% of the Managed Care eligible population in the county must have access to the required specialist within fifty (50) miles and within seventy-five (75) minutes or less driving time.
3. OB/GYN: OB's acting as a primary care physician should be included in the PCP section of the GeoAccess report. Also include all OB/GYN's in the specialty section of the GeoAccess report.
4. FQHC/RHC: For FQHC's and RHC's Providers acting as PCP include them in the PCP section of the GeoAccess report. FQHC's and RHC's acting as specialists include them in the appropriate required specialty GeoAccess report.
5. Hospitals: For hospitals the standard is 90% of the Managed Care eligible population in the county must have access to a hospital within fifty (50) miles and within seventy-five (75) minutes or less driving time.

The geocoded solution should include only required Providers (i.e. those with a status of 1 in Table 6.1 in the contract). All PCP's are to be reported in a single combined report and all specialists are to be included in separate reports for each specialty. GeoAccess reports must be uploaded to the MCO's SharePoint Required Submissions library according to the contract in section 6.2.3.

The MCO is responsible for ensuring that all enrolled Providers are eligible to participate in the Medicaid Program. If a Subcontractor is **not** accepting new Medicaid MCO Members, the Subcontractor must identify why any Provider not accepting new members should be included on the GeoAccess report produced for SCDHHS. Additionally if a PCP or specialist does not have admitting privileges to at least one of the contracted Hospital(s) listed on the report, the MCO must provide a detailed description of the mechanisms that will be used to provide services to Medicaid MCO Members. SCDHHS reserves the right to disapprove any Provider Network submission based on the information provided. The MCO shall check the LEIE and other applicable federal reporting sources to ensure compliance with the MCO contract.

The MCO shall only submit enrolled Providers who have completed the MCO's contract, have been credentialed by the MCO, and have submitted a completed Provider enrollment package to SCDHHS. The contract may not be executed by the MCO until SCDHHS has approved the county.

Network adequacy is determined by SCDHHS based on the GeoAccess solution report and the MCO's projected maximum Medicaid MCO Member Enrollment for a specific county, member proximity guidelines to Providers, and historical service patterns.

There are four (4) different Provider statuses listed on the County Network spreadsheet:

- Status “1” = Required Provider; Requires an executed contract for a period of no less than one (1) year
- Status “2” = MCOs are not required to contract with this Provider type (RHC/FQHC) unless this Provider type is in support of network approval.
- Status “3” = Attestation; MCOs will provide services through any means necessary. While MCOs may attest to status “3” services, a contract is not required when MCO reimbursement is at or above the established Medicaid fee schedule for the date of service. A contract is required should an MCO choose to compensate at a rate less than the Medicaid fee schedule for the date of service.
- Status “4” = Additional services provided for and reimbursed by the MCO that are not available under Medicaid. Such services must comply with the terms of the Policies and procedures, and contract between SCDHHS and the MCOs. MCOs must have contracts to support all Additional Services. Before an MCO may offer these services, prior approval is required from the SCDHHS.

The goal is to ensure the approval of a network that will guarantee appropriate level of access to care for Medicaid MCO Members.

If the submitted Provider network is determined not to be adequate by SCDHHS, the submitted Provider network, documentation and reasons for denial of the county by the Department of Health Services is shared with management at the executive levels. The MCO will be notified, in writing (either electronic or paper format), that the network is not approved and the specific reasons for that decision. The MCO may resubmit this network for consideration once the reasons for disapproval have been corrected.

If SCDHHS determines the MCO has submitted an adequate network for a county, SCDHHS will approve the network, set the effective date for enrollment and notify the MCO in writing. SCDHHS will also notify the MMIS system to modify the “counties served” indicator in the Provider file to allow Medicaid MCO beneficiary enrollments to be processed. Also, both the enrollment and transportation brokers are informed of the addition of approved counties.

Upon SCDHHS approval of a network, the MCO must maintain its adequacy and cannot **refuse** to accept new members; change their Medicaid MCO Member assignment formula; or limit member choice of Providers **without prior approval by SCDHHS**, under penalty of sanctions and/or damages.

SCDHHS may modify the auto assignment, or Medicaid MCO Member choice processes, at its discretion. If an MCO requests to limit auto-assignment and/or Medicaid MCO beneficiary choice, SCDHHS will re-evaluate the adequacy of the county network. As a result of this review, SCDHHS reserves the right to rescind its approval of the affected county (ies) and institute a transition plan to move the MCO’s Medicaid Members to other managed care options. The affected MCO will pay all cost associated with the transition plan.

SCDHHS reserves the right to perform a review (on-site or off-site), announced or unannounced. Upon request MCOs are required to provide access to electronic copies of the Provider Subcontracts, including any applicable approved amendments, credentialing, Hold Harmless Agreements and any other documentation SCDHHS deems necessary for review. Access to requested documentation must be provided to the SCDHHS within seven (7) calendar days of the request.

At its discretion, SCDHHS may request the MCO to provide copies (electronic or paper) of all original contracts, credentialing materials, and rate information at no cost to SCDHHS. MCOs must deliver the requested documentation to SCDHHS within seven (7) calendar days of the request. SCDHHS may, at its discretion, contact Subcontractors to verify the accuracy of the information submitted by the MCO. Renewals of existing contracts cannot be for a time period of less than twelve (12) months.

Section 6.2.3.1 through Section 6.2.3.2: The MCO shall submit a complete listing of its Provider network to SCDHHS on a monthly basis. The submission shall be due no later than the Thursday prior to cut off of each month. Delivery of this file may coincide with the delivery of the file to the enrollment broker. The file format for this submission can be found in the report companion guide and will mirror the format submitted to the enrollment broker.

NETWORK TERMINATION / TRANSITION PROCESS

The loss of an essential medical Provider(s) in a network could seriously impact the MCO's ability to deliver medical services to its Medicaid MCO Members in compliance with federal regulations and contractual obligations to SCDHHS. This loss could ultimately result in 1) the SCDHHS-supervised transition of Medicaid MCO Members to acceptable alternate Providers, or 2) the termination of the MCO's authority to serve the residents of one or more counties.

There are four ways in which the Network Termination or Transition process can be initiated:

1. SCDHHS Health Services staff receives verbal and written notification from the MCO, along with a copy of the termination letter from the essential Provider(s). A copy of the termination letter must be provided to SCDHHS within twenty-four (24) hours of receipt of essential Provider(s)'s intent to terminate its contract(s) with the MCO. Any termination must be effective at the end of the month of termination since the MCO has been compensated for a full month of services for each Medicaid MCO Member.
2. SCDHHS Health Services staff receives verbal or written notification directly from essential Provider(s) of its intent to terminate its contract with the MCO. SCDHHS will notify the MCO in writing (by letter or email) within twenty-four (24) hours of receipt of the essential Provider's intent to terminate.

3. During the bi-annual review of the Provider Network Listing Spreadsheet, or during a review conducted at the discretion of SCDHHS, SCDHHS determines the MCO does not meet the network adequacy standards contained in the MCO Contract and/or this guide.
4. The MCO may initiate a voluntary request to terminate a county(ies)

Should SCDHHS initiate the Network Termination or Transition process, the MCO will be notified within twenty-four (24) hours of the decision in writing (letter or email). Decisions to terminate a county (ies) will require the MCO to terminate all Provider subcontracts within the county (ies) involved, providing written confirmation to SCDHHS of such terminations. Exceptions may be made at SCDHHS' sole discretion on a case-by-case basis upon review of documentation provided by the MCO at SCDHHS' request.

Upon initiation of the Network Termination or Transition process, SCDHHS will schedule the initial meeting with designated MCO staff. At the initial meeting, the SCDHHS Managed Care staff will establish a project plan in support of the network termination or transition.

SCDHHS is responsible for creating, maintaining, and updating the project plan with input from the MCO. The MCO will be required to submit new networks, using the standard county network submission format. Both electronic and hard copies (paper) must be submitted to the MCO's program manager within the specified time frame. Failure of the MCO to provide this information within the specified time frame will result in a delay of the termination and the MCO will incur additional cost. SCDHHS reserves the right to obtain copies of original contracts (including rates, lists of services provided, credentialing applications, and approvals, and other information as requested in a format to be determined by the SCDHHS).

Additionally, during the transition, auto assignment and choice will be turned off (meaning new beneficiaries will not be assigned or allowed to choose the MCO) in the transitional or terminated county(ies) and surrounding county (ies). Upon SCDHHS's completion of the review to determine the impact the transition/termination will have on the surrounding county (ies), SCDHHS will make a final determination on whether or not to also close the surrounding counties to auto assignment and choice.

Any additional incremental cost (charges) incurred by the Enrollment Broker or SCDHHS during this Network Termination or Transition process will be reimbursed by the MCO.

Voluntary Termination of a County (ies)

The following steps must be taken by an MCO requesting to voluntarily terminate its active status within a county:

- Submit three copies, with CPA's original signature, of current financial statements demonstrating fiscal soundness of the company's operations within the state of South Carolina

- Submit three copies, with a CPA's original signature, of current financial statements demonstrating the impact requested county (ies) would have on the overall fiscal soundness of the company's operations within the state of South Carolina should SCDHHS deny the request to restrict membership
- Copies of all executed subcontracts, including rates, from the requested counties; MCO understands, if SCDHHS agrees to the voluntarily termination, all healthcare Provider contracts, for example but not limited to: Hospital, PCP, specialties, physicians, etc. will be terminated in accordance with SCDHHS' scheduled project plan
- Updated county network submissions reflecting the removal of the following Providers from your South Carolina network:
 - a. **Thirty (30) of the requested counties for Primary Care Providers (Primary Care includes those OB/GYN Providers who have agreed to serve as a Primary Care Provider for pregnant members)**
 - b. A 50-mile radius from the border of the requested counties for Specialty and Ancillary Service Providers;
 - c. Hospitals:
 - i. Up to and including a 100-mile diameter from the border of the requested counties for Children and Level I Trauma Hospitals;
 - ii. Up to and including a 75-mile diameter from the border of the requested counties for urban or county hospitals servicing more than one county;
 - iii. Up to and including a 50-mile diameter from the border of the requested counties for rural county hospitals.

Upon SCDHHS's approval to voluntarily terminate a county (ies), the MCO must provide written confirmation of the termination of all Provider subcontracts within the county (ies) involved.

Upon receipt of all requested information, as outlined above and any additional requested information, SCDHHS will review and consider all submissions and render a decision within fifteen (15) business days from the date of receipt of the final information requested; however, SCDHHS reserves the right to extend the review period beyond fifteen (15) days as needed.

Should SCDHHS agree to allow the MCO to voluntarily terminate a county (ies), SCDHHS will develop a transition project plan outlining timeframes and deliverables for all parties involved. Additionally, during the transition timeframe prior to the voluntary closing of the county (ies), auto assignment and choice will be "turned off" (meaning new beneficiaries will not be assigned or allowed to choose the MCO) in the requested county (ies) and surrounding county (ies). Once SCDHHS has completed its review and determined whether the surrounding county (ies) is affected by the voluntary closing of

the county (ies), SCDHHS will make its final determination on whether or not to close the additional county (ies). Beneficiary choice period will be opened upon conclusion of SCDHHS's review.

The MCO understands and acknowledges it will be excluded from submitting all of the necessary information to re-enter the voluntarily withdrawn county (ies) for a minimum of twelve (12) months from the termination date of the county (ies) involved. SCDHHS reserves the right not to allow the MCO to re-enter the county (ies) from which it voluntarily withdrew indefinitely.

Any additional incremental cost (charges) incurred by the Enrollment Broker or SCDHHS during this Network Termination or Transition process will be reimbursed by the MCO.

6.3 Attestations

For all cites in Section 6.3, please refer to the contract for all requirements between MCO and SCDHHS.

6.4 Regional Provider Networks

For all cites in Section 6.4, please refer to the contract for all requirements between MCO and SCDHHS.

7.0 PAYMENTS

7.1 Financial Management

For all cites in Section 7.1, please refer to the contract for all requirements between MCO and SCDHHS.

7.2 Capitation Payments from the Department to CONTRACTOR

For all cites in Section 7.2.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 7.2.2: SCDHHS uses a number of actuarially sound methodologies to develop its managed care rates. These methodologies can be found in the Managed Care Data Book on the SCDHHS website, <https://msp.scdhhs.gov/>. SCDHHS encourages the MCO to reimburse out-of-network Providers (non-participating Providers) at the established Medicaid fee-for-service rate for payment of services provided to the MCO's enrollees.

Some payments, however, may be paid to the MCO through an adjustment. If the adjustment processed by the SCDHHS Health Services area is a "gross-level" adjustment, information on the MCO's remittance advice form will not be member specific; however, the MCO will receive detailed documentation from an SCDHHS

representative for each of these adjustments. It is the MCO's responsibility to reconcile the "gross-level" adjustments sent to the MCO. Gross level adjustments completed by SCDHHS will be made based on the premium payment made for each member at the monthly cutoff date.

The following payments and/or debits will be assessed through gross-level adjustments, rather than through capitation.

Capitation / Premium Payment Adjustment:

When it is determined by SCDHHS a capitated premium payment should have (or have not) been paid for a specific Medicaid MCO Member, an adjustment will be processed to correct the discrepancy. The MCO should contact their SCDHHS Program Manager to report any possible discrepancies.

Retrospective Review and Recoupment

Dual Eligible:

Beneficiaries who are dually Eligible (Medicare and Medicaid) are not Eligible to be in an MCO; however, individuals enrolled in an MCO may receive Medicare eligibility retroactively. Upon notification of Medicare Enrollment, MCOs may recoup Provider payments in accordance with the code of federal regulations. Each month the MCO will receive a retroactive Medicare eligible report. This report will be individualized for each MCO operating within South Carolina and contain member specific information. The information will be posted to the MCO's SharePoint site in the monthly library. Premium payments for members reflected on this report will be adjusted for the months the member was retroactively Medicare eligible for up to one year of retroactive eligibility to ensure the Department correctly reimburses the health plan at the dual rate of reimbursement. For example, a member is identified in July of 2014 that gained retroactive Medicare eligibility back to May of 2013, SCDHHS will adjust the MCO's premium payments back to August of 2013. The report posted monthly to each individual MCO monthly library in SharePoint will reflect each specific adjustment and time period. Upon notification of the Medicare retroactive enrollment, MCOs are required to notify Providers within sixty (60) days and initiate recoupment procedures where the MCO paid as the primary payer. Providers of service(s) to these members then may file claims directly to Medicare in order to receive reimbursement.

Premium Payments made for Deceased Membership:

There are instances where premium payments might be made erroneously for beneficiaries that have passed away. In all of these instances, the department will seek to recoup the premium payment that was made in error. Each month the MCO will receive a report from SCDHHS indicating those members that have passed away where the agency made a premium payment for the member and should not have. This report will be individualized for each MCO operating within South Carolina and contain member specific information. The information will be posted to the MCO's SharePoint site in the monthly library. Premium payments for members reflected on this report will be adjusted for the months the member was deceased and a premium payment

occurred. For example, a member is identified in July of 2014 as deceased, SCDHHS will recoup any premium payments made after July of 2014. The report posted monthly to each individual MCO monthly library in SharePoint will reflect each specific adjustment and time period.

Sanctions:

The preferred method for enforcing monetary sanctions imposed by SCDHHS is via the debit adjustment process. Reasons for sanctions are defined in the Section 18.

Interim Hospital Payments:

In the event hospital claims for a Beneficiary have met the limitation criteria as stated in the SCDHHS Hospital Services Provider Manual, an interim payment may be made. These limitations are:

1. Charges have reached \$400,000 and
2. Discharge is not imminent.

Incentive Payments:

MCO incentive payments for Patient Centered Medical Homes (PCMH) Provider payments, and Centering program incentives will all be paid through gross level adjustment after a quarter has ended.

Provider-designated incentives are those incentives paid by the MCO to qualified Providers for achieving designated goals. Provider-designated incentives are paid for the following programs:

- Centering Program

MCO-designated incentives are those incentives paid to the MCO by the Department for specific activities and meeting specified performance targets. MCO-designated incentives are paid for the following programs:

- PCMH Development and Operation

Provider Quality Incentive Programs

Patient Centered Medical Home (PCMH):

- The goal is to encourage the development of Patient Centered Medical Homes (PCMH) as defined through the certification process through the National Committee for Quality Assurance (NCQA), as well as, other recognized PCMH recognition bodies that SCDHHS may deem credible. SCDHHS has deemed that FQHCs who have already achieved or who had begun the process to achieve JCAHO PCMH recognition by July 2012, are eligible for the incentives. Any FQHC with this designation would be eligible for the PCMH level III incentive payment.

- Quarterly Per Member Per Month (PMPM) payments will be made to both MCOs and Providers in four payment levels:
 - Application Period: \$0.50 Provider/\$.10 Health Plan
 - Level I Certification: \$1.00 Provider/\$0.15 Health Plan
 - Level II Certification: \$1.50 Provider/\$0.20 Health Plan
 - Level III Certification: \$2.00 Provider/\$0.25 Health Plan
 - Once SCDHHS has made its quarterly payments to the MCO, the MCO must make payment to the qualifying practices within thirty (30) days of the SCDHHS payment.
 - **Application Process Requirements:**
 - Initially the MCO must complete and submit the information as outlined in the Reports Companion Guide with a copy of the application and a defined timeline for the Provider to achieve PCMH recognition. After the initial submission the MCO or CSO is not required to submit the documentation again until the eighteenth (18th) month. The application process cannot exceed eighteen (18) months. If SCDHHS, at its discretion, determines the documentation submitted by the MCO doesn't justify the incentive payments already made to the MCO; SCDHHS, at its discretion, may recover the total amount of incentives paid (both to the Provider and MCO) through a gross level adjustment.
 - If the Provider achieves PCMH recognition, both the Provider and MCO will receive the increased incentive beginning the month in which PCMH recognition was achieved.
 - **Documentation Requirements for Providers Who Achieve PCMH Recognition:**
 - Initially the MCO must complete and submit the information as outlined in the Reports Companion Guide. If the Provider achieves the next level (i.e., Level I to Level II), the Provider and Plan will receive the increased incentive in the month in which PCMH recognition was achieved.
 - The MCO must include an attestation with each report submission verifying the status (Application, Level I, Level II, and Level III) of all Providers' PCMH recognition as a PCMH. Additionally, the MCO must indicate the total number of Medicaid MCO Members assigned to each qualifying Provider.
 - The attestation template is located in the Reports Companion Guide.
- Effective with the submission of the July 1, 2015 PCMH files, SCDHHS will not pay MCOs for retroactive PCMH data outside of the prior quarter. This modification will only allow the MCO to submit and reimburse qualified practices for data reported in the current or previous reporting quarter. For example, if the MCO is submitting Q1-FY2016 (July 2015 – September 2015) data, under the

new policy, the MCO can additionally submit qualified practice membership data for Q4-FY2015 (April 2015 – June 2015), but not prior to this time period.

- **Centering Program:**

- The following programs are currently certified in South Carolina to provide these services:
 - GHS-OBGYN Center
 - Mountain View OBGYN-Easley
 - MUSC Women’s Health
 - USC Women’s Specialty Clinic
 - AnMed Health Family Medicine Residency Program
 - Sumter OBGYN
 - Carolina OBGYN (Murrells Inlet and Georgetown)
- The following programs are currently under review for certification in South Carolina:
 - Lexington Women’s Care (Lexington, SC)
 - Palmetto Women’s Care (Manning, SC)
 - Coastal Carolina OB-GYN (Conway, SC)
 - Carolina Women’s Center (Clinton)
 - Montgomery Center for Family Medicine (Greenwood)
- The goal is to adopt a program wherein pregnant Medicaid MCO Members meet as a group to discuss their health, as well as to provide peer support. The Centering Healthcare Institute must have certified the centering program used by Provider.
- The MCO will reimburse the Provider \$30 for each centering visit up to the fifth visit to the Provider. The MCO will be reimbursed \$40 per member per visit up to a maximum of five (5) visits.
- MCOs and Providers must follow the procedures described below to qualify for the Centering Pregnancy group prenatal care incentive.
- Providers must submit claims for group clinical visits for the management of pregnancy using procedure code 99078 and modifier TH, with one of the following diagnosis codes if dates of service are prior to October 1, 2015:

Managed Care Organizations Policy and Procedure Guide

DIAGNOSIS CODES				
V220	V221	V222	V230	V231
V232	V233	V2341	V2342	V2349
V235	V237	V2381	V2382	V2383
V2384	V2385	V2386	V2389	V239

- o Providers must submit claims for group clinical visits for the management of pregnancy using procedure code 99078 and modifier TH, with one of the following diagnosis codes if dates of service are on or after October 1, 2015:

DIAGNOSIS CODES				
Z34.00	Z34.01	Z34.02	Z34.03	Z34.80
Z34.81	Z34.82	Z34.83	Z34.90	Z34.91
Z34.92	Z34.93	Z33.1	O09.00	O09.01
O09.02	O09.03	O09.10	O09.11	O09.12
O09.13	O09.40	O09.41	O09.42	O09.43
O09.211	O09.212	O09.213	O09.219	O09.291
O09.292	O09.293	O09.299	O09.30	O09.31
O09.32	O09.33	O09.511	O09.512	O09.513
O09.519	O09.521	O09.522	O09.523	O09.529
O09.611	O09.612	O09.613	O09.619	O09.621
O09.622	O09.623	O09.629	O09.811	O09.812
O09.813	O09.819	O09.821	O09.822	O09.823
O09.829	O09.891	O09.892	O09.893	O09.899
O09.70	O09.71	O09.72	O09.73	O09.90
O09.91	O09.92	O09.93		

- o For claims with procedure code 99078 with modifier TH to be considered for reimbursement, they must be submitted for the same date of service as claims by the same Provider for procedure codes 99211, 99212, 99213, 99214, or 99215 and modifier TH. The MCO will utilize their current reimbursement methodology when reimbursing for the evaluation and management code billed on the same date as procedure code 99078.
- o For each claim with procedure code 99078 with modifier TH, the MCO will reimburse the Provider \$30, with a total maximum reimbursement of \$150 per patient payable to the Provider by the MCO. SCDHHS will analyze MCO encounter data on a quarterly basis. Reimbursement will be based on the number of times 99078 with modifier TH is identified within the encounter data. The MCO will be reimbursed \$40 per member per visit up to a maximum of five (5) visits. Total maximum MCO reimbursement for any single member who has completed at least five (5) visits with a Centering Pregnancy program will be \$200. MCO reimbursement for the Centering incentive will be quarterly by gross-level adjustment after the quarter's encounter data has been analyzed.
- o To qualify for the Centering Pregnancy group prenatal care incentive for the management of pregnancy, the Medicaid member must be a female between the ages of 10 through 55 years of age. Providers must be site approved by the Centering Healthcare Institute or under contract for a Model Implementation Plan in preparation for formal site approval, and must conduct groups consistent with the Centering Pregnancy model. Group clinical visits must last at least one (1) hour but no longer than two (2) hours, with a minimum of two (2) clients and a maximum of twenty (20) clients. Providers must use educational materials from the Centering Pregnancy curriculum, and these must be incorporated into the educational portion of the group clinical visit.

Process for Recovery of Incentive Payments

SCDHHS reserves the right not to make incentive payments to the MCO if it fails to submit timely and accurate reports and in the format outlined here and in the Report Companion Guide. If SCDHHS discovers the MCO has submitted erroneous information SCDHHS, at its discretion, may recover incentive payments. SCDHHS recovery of incentive payments may include both the MCO's and Provider's portion of the incentive payment, and may include liquidated damages as outlined in the MCO Contract.

Affordable Care Act (ACA) Primary Care Enhanced Payments for Eligible Primary Care Physicians:

The Affordable Care Act mandates that an enhanced payment be made for those physicians attesting to meeting criteria as a primary care physician for CY 2013 and 2014. This enhanced payment will be made as a supplemental gross adjustment to the plan for all the MCO's Providers meeting the enhanced payment criteria. The MCO will be provided a file of all eligible services and Providers meeting the payment criteria. The

MCO will be responsible for and must reimburse Providers based on the data provided by SCDHHS for this project on a quarterly basis. Once SCDHHS has made its quarterly payments to the MCO, the MCO must make payment to the qualifying practices within 30 days of the SCDHHS payment.

After calendar year 2014 SCDHHS will be including any additional monies for rate enhancement in the MCO per member per month (PMPM) capitation rate. Please see the rate book for January 1, 2015 and thereafter for additional information regarding rate calculations.

Manual Maternity Kicker Payments:

SCDHHS reimburses a maternity kicker payment for each female that presents with a pregnancy. This is done through an automated matching process described in section 3 of this guide. If the matching process does not occur properly for a Medicaid member the MCO may report this to SCDHHS through a monthly manual maternity kicker report described in this guide and the MCO report companion guide. Any manual maternity kicker reports will be paid through a gross level adjustment after analysis of the report has occurred.

MCO Withhold:

The MCO quality withhold program will be performed through a “gross level” adjustment in the month after a quarter has ended and will be based on 1.5% of total premiums paid for the quarter minus 4% for the supplemental teaching portion of the monthly capitated rate.

MCO Withhold Return:

The return of the MCO quality withhold will be performed through a “gross level” adjustment. This refund will be completed after the department has thoroughly analyzed all HEDIS data submitted by the health plans and after the department has determined the equitable redistribution of the withhold pool for each of the health plans. The department reserves the right to determine individual distribution levels for all MCO’s.

For all cites in Section 7.2.3 through Section 7.2.5, please refer to the contract for all requirements between MCO and SCDHHS.

Section 7.2.6: MCOs may retrospectively recoup payments from Subcontracted Providers if the MCO determines the service was reimbursed in error and was the responsibility of SCDHHS. MCOs must notify Providers of their intent to retrospectively recoup payments from the Subcontractor within 275 calendar days from the date of service.

For all cites in Section 7.2.6.1 through Section 7.2.7.3, please refer to the contract for all requirements between MCO and SCDHHS.

7.3 Payments from CONTRACTOR to Subcontractor

Background

Social Security Act Section 1903(m)(A)(ix) requires that managed care plans shall provide payment to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) not less than the level and amount of payment which the plan would make for the services if the services were furnished by a Provider which is not a FQHC or RHC. The Social Security Act 1902 (bb) provides that the State shall provide a supplemental payment; if any, for the difference between the payment by the managed care plan and the fee-for-service rate that the FQHC or RHC would have received. The supplemental payments, herein referred to as the Wrap-Around payment methodology, are calculated and paid to ensure these entities receive reimbursement for services rendered to Medicaid MCO Members at least equal to the payment that would have been received under the traditional fee-for-service methodology. SCDHHS is the state agency responsible for ensuring the supplemental payment determinations (Wrap-Around methodology) are calculated at least every three (3) months. SCDHHS will provide these reconciliations to the entities on a quarterly basis.

Section 7.3.1 through Section 7.3.1.4: The Medicaid MCO shall submit a report, quarterly, to its SharePoint quarterly library, all paid and denied encounter/claim data, by date of service, for all services rendered by FQHCs and RHCs for supplemental payment determination (Wrap-Around methodology) reconciliation purposes. Services eligible for Wrap-around methodology must meet fee-for-service coverage requirements. There shall be only one (1) encounter per day per recipient eligible for Wrap-around payment. The Contractor shall submit the name of each FQHC/RHC and detailed Medicaid encounter data paid to each FQHC/RHC. This information shall be submitted in the format required by the Department no later than sixty (60) days from the end of the quarter to the SCDHHS. This is an exception to the normal quarterly submission requirement of fifteen (15) days after the end of a quarter.

Based on the FQHC/RHC's fiscal year end, an annual reconciliation of MCO payments and services to allowable reimbursement based on the FQHC/RHCs encounter rate will be determined. To complete this process, the following will be required:

1. Within one (1) year and sixty (60) days of the FQHC/RHC's quarterly report, all quarterly wrap-around files for the applicable quarter should be re-run (i.e. updated) in order to capture additional encounter and payment data not available or processed when the applicable quarter was originally run.
2. Transmission requirements remain the same as the interim quarterly submissions. That is, the updated files should be uploaded to the MCO's SharePoint quarterly library and the appropriate staff notified of it being uploaded to the site.
3. 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 SCDHHS which may be found in the Reports Companion Guide. For your convenience an excel report template is available at <https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates>. If the submission is less than 97% accurate, the Department, at its discretion, may apply the liquid damages to the MCO as outlined in the MCO Contract with the Department (\$1,500 per day).

FQHC/RHC Wrap Data Files (Spreadsheets)

Encounter detail data and summary data shall be provided to SCDHHS as two (2) separate data spreadsheets in one Microsoft Excel workbook. A participation list shall be provided in a separate file. For your convenience an excel report template is available at <https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates>.

Section 7.3.2: The following beneficiaries are excluded from making co-payments:

- Children under 19 years of age
- Pregnant women
- Institutionalized individuals (such as persons in a nursing facility or ICF-MR)
- Members of a federally recognized Indian tribe are exempt from most co-payments. Tribal members are exempt when services are rendered by the Catawba Service Unit in Rock Hill, South Carolina and when referred to a specialist or other medical provider by the Catawba Service Unit.

The following services are not subject to a Medicaid copayment:

- Medical equipment and supplies provided by the Department of Health and Environmental Control (DHEC)
- Orthodontic services provided by DHEC
- Family planning services
- Substance abuse services provided by the Department of Alcohol and Other Drug Abuse Services
- End Stage Renal Disease (ESRD) services
- Infusion center services
- Emergency services in a hospital setting
- Home and Community Based Waiver services
- Hospice services

For all cites in Section 7.3.3 , please refer to the contract for all requirements between MCO and SCDHHS.

7.4 Payment Standards

For all cites in Section 7.4, please refer to the contract for all requirements between MCO and SCDHHS.

7.5 Prohibited Payments

For all cites in Section 7.5, please refer to the contract for all requirements between MCO and SCDHHS.

7.6 Return of Funds

For all cites in Section 7.6, please refer to the contract for all requirements between MCO and SCDHHS.

8.0 Utilization Management

8.1 Management

For all cites in Section 8.1.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 8.1.2: Utilization Management policies and procedures must be uploaded to the Department's SharePoint site in the MCO's Annual libraries at the frequency defined in the contract between the MCO and SCDHHS.

8.2 Contractor Utilization Management (UM) Program Requirements

For all cites in Section 8.2, please refer to the contract for all requirements between MCO and SCDHHS.

8.3 Practice Guidelines

For all cites in Section 8.3, please refer to the contract for all requirements between MCO and SCDHHS.

8.4 Service Authorization

For all cites in Section 8.4.1 through Section 8.4.2.6, please refer to the contract for all requirements between MCO and SCDHHS.

Section 8.4.2.7: The MCO utilization management policies and procedures must include mechanisms for a preferred Provider program described in this section of the contract. The policies must identify the specific instances where Providers will qualify for the

preferred Provider service authorization process, the benefit to qualifying Providers and any limitations of the program that the MCO will implement. The preferred Provider policy must be uploaded along with all other Utilization Management policies to the MCO's SharePoint annual library at the frequency defined in Section 8.1.2.

8.5 Timeframe of Service Authorization Decisions

For all cites in Section 8.5, please refer to the contract for all requirements between MCO and SCDHHS.

8.6 Standard Service Authorization

For all cites in Section 8.6, please refer to the contract for all requirements between MCO and SCDHHS.

8.7 Expedited Service Authorization

For all cites in Section 8.7, please refer to the contract for all requirements between MCO and SCDHHS.

8.8 Exceptions to Service Authorization Requirements

For all cites in Section 8.8, please refer to the contract for all requirements between MCO and SCDHHS.

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

For all cites in Section 8.9, please refer to the contract for all requirements between MCO and SCDHHS.

9.0 Grievance and Appeals Procedures

9.1 Member Grievance and Appeal

For all cites in Section 9.1 through 9.1.1.3.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 9.1.2: The MCO will furnish Medicaid MCO Members approved written information regarding the nature and extent of their rights and responsibilities as a Medicaid MCO Member of the MCO. The minimum information shall include:

- a) A description of the managed care plan
- b) A current listing of practitioners providing health care
- c) Information about benefits and how to obtain them
- d) Information on the confidentiality of patient information
- e) Grievance and appeal rights

- f) Advance directive information as described in 42 CFR 417.436 and 489
- g) Eligibility and enrollment information

The MCO will maintain a Grievance and appeal system that:

- a) Has written policies and procedures that are distributed to Medicaid MCO members. These policies and procedures must comply with the provisions of the MCO Contract.
- b) Informs Medicaid MCO members they must exhaust the MCO's Appeal process prior to filing for a state fair hearing, and informs the Medicaid MCO members of the state fair hearing process and its procedures.
- c) Attempts to resolve grievances through internal mechanisms whenever possible and to contact the member by letter or telephone providing them with the MCO's resolution.
- d) Maintains a separate spreadsheet for oral and written Grievances and Appeals and records of disposition

The MCO shall forward any adverse decisions to SCDHHS for further review/action upon request by SCDHHS or the Medicaid MCO Members.

Members have a due process right to appeal an adverse action by the MCO including a service denial, delay, or limitation. Members must follow the MCO's appeals process as outlined in the MCO's Member handbook. Upon exhaustion of the MCO's appeals process, the MCO must notify the member by certified mail, return receipt requested of the member's right to request a state fair hearing within thirty (30) days of the delivery of the denial notice. The date of the return receipt will begin the thirty (30) day time period for the Member to request a state fair hearing. The plan must ensure that the denial notice is delivered to the Member's current address. If the mail was unable to be delivered (letter was refused, or address was invalid) the 30-day time period will begin upon the final attempt to deliver the denial notice. In all situations regarding timeliness, the Hearing Officer retains the right to determine whether the request for a state fair hearing was timely. The Member has a due process right to request a state fair hearing. If the Member requests that their Provider represent them in the state fair hearing, the Provider must obtain, in advance, the Member's signature authorizing Provider representation. The Provider cannot require the Member appoint them as his or her representative as a condition of receiving services.

In the event a Medicaid MCO Member or Provider, acting on behalf of a Medicaid MCO Member, requests a State Fair Hearing, the MCO must transmit copies of all communication (written and electronic) to the SCDHHS MCO program manager concurrent with communication to the Medicaid MCO Member, the Provider, and the SCDHHS hearing officer.

For all cites in Section 9.1.3 through 9.1.3.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 9.1.3.2: Provides to SCDHHS on a quarterly basis summaries of the Grievances and a written Appeals log which occurred during each month of the reporting period to include:

- Nature of Appeal
- Date of the filing
- Resolutions and any resulting corrective action

The summary grievance information and the appeal log shall be uploaded to the MCO's SharePoint quarterly library.

The MCO shall forward any adverse decisions to SCDHHS for further review/action upon request by SCDHHS or the Medicaid MCO beneficiary. In the event a Medicaid MCO beneficiary or Provider, acting on behalf of a Medicaid MCO Member, requests a State Fair Hearing, the MCO must transmit copies of all communication (written and electronic) to the SCDHHS MCO program manager concurrent with communication to the Medicaid MCO Member, the Provider, and the SCDHHS hearing officer.

The MCO must upload their written beneficiary grievance and appeal policies to its SharePoint Required Submission library. The MCO must upload any subsequent changes and/or revisions to its Grievance and Appeal Policy and Procedures to its SharePoint Required Submission library for approval prior to implementation.

For all cites in Section 9.1.4 through Section 9.1.9.2, please refer to the contract for all requirements between MCO and SCDHHS.

9.2 Provider Dispute System

For all cites in Section 9.2, please refer to the contract for all requirements between MCO and SCDHHS.

For all cites in Section 9.2 through 9.2.13 please refer to the contract for all requirements between MCO and SCDHHS.

Section 9.2.14: Provides to SCDHHS on a quarterly basis written summaries of the Provider level II disputes which occurred during each month of the reporting period to include:

- Nature of the dispute
- Date of the filing
- Resolutions and any resulting corrective action as a result of the complaint

These reports must be uploaded to the MCO's SharePoint quarterly library on a quarterly basis.

10.0 Third Party Liability

10.1 General

Third-Party Liability (TPL) is essentially analogous to coordination of benefits and subrogation for health insurance. (Medicaid, however, is secondary to all other insurance.) so the savings from TPL are substantial. Federal law requires states to have a TPL program that meets the requirements of federal regulations. In South Carolina, the state statute and the federal regulations are the Third Party Liability (TPL) program. The program involves identification of other payers, including, but not limited to, group and other health insurers (including employer self-funded and ERISA health benefit plans), liability insurance, and worker's compensation insurance.

MCOs have an incentive to pursue payment from third parties because the premiums that Healthy Connections Medicaid pays to the MCOs includes a reduction based on an actuarial assumption of the expected level of TPL activity in the market. As risk based organizations it is assumed that MCOs will take advantage of this opportunity and pursue the third party payment. However, even without this incentive, federal law requires that a TPL program be in place. Contractors have an obligation to find out as much as possible about the third party payers that may be responsible for some or all of the services delivered to the Medicaid managed care enrollee. Providers should be instructed to bill any known third party for services prior to billing the MCO.

10.2 Departmental Responsibilities

Section 10.2.1: SCDHHS has a contract in place for insurance verification services. Leads from the following sources are verified by the insurance verification contractor before being added to the TPL database:

- The Department of Social Services (TANF/Family Independence and IV-D)
- The Social Security Administration
- Community Long-Term Care staff
- Data matches with The Department of Employment and Workforce, TRICARE, and IRS
- Insurer leads
- Leads from claims processing
- Providers

Verification includes policy and Beneficiary effective dates, persons covered by the policy, policy holder name, policy holder birthdate and social security number, policy identification number, group information, and claim filing addresses. This data is updated continuously as new information is received. Only verified TPL coverage data will be passed to MCOs.

Section 10.2.2 through Section 10.2.3: It can take up to twenty-five (25) days for a new policy record to be added to a beneficiary's eligibility file and five (5) days for corrections and updates of an existing record. New policy information and updates are added to the Medicaid Management Information System (MMIS) every working day; information is passed to the MCOs at least monthly.

10.3 CONTRACTOR Responsibilities

For all cites in Section 10.3, please refer to the contract and to the TPL sections outlined below in this guide for all requirements between MCO and SCDHHS.

10.4 Cost Avoidance

Section 10.4.1 through Section 10.4.4: Cost Avoidance refers to the practice of rejecting a claim based on knowledge of an existing health insurance policy which may cover the claim. Providers must report primary payments and denials to the MCOs to avoid rejected claims. The majority of services covered by the MCOs are subject to cost avoidance. The only exclusions to cost avoidance are those services designated as pay and chase services listed below:

- Preventive pediatric services
- Dental EPSDT services
- Maternal health services
- Title IV- Child Support Enforcement insurance records
- Certain Department of Health and Environmental Control (DHEC) services under Title V

While Providers of such services are encouraged to file with any liable third party before the MCO, if they choose not to do so, the MCO will pay the claims and bill liable third parties directly through a Benefit Recovery program.

The MCO must perform cost avoidance whenever it has knowledge of a responsible third party payer except in the instances described above. When a claim is rejected for TPL reasons, the amount is recorded as cost avoidance savings and reported to Healthy Connections Medicaid.

MCO's must require network (both contracted and non-contracted) Providers to ascertain whether or not a member has existing TPL coverage at the point of service. All Providers must bill the third party payer before billing the MCO.

If the probable existence of TPL for a particular enrollee has been determined by SC Healthy Connections Medicaid or by the MCO, the MCO must deny claims and return them to the Provider, with the instruction that the Provider must bill the third party payer prior to billing a Medicaid managed care plan, unless the service is one that would fall under "pay and chase". When denying a claim for TPL, the MCO must give the Provider

its TPL data so that the Provider can appropriately submit his claim to the third party payer.

Federal regulations do not permit the state to deny payment for claims for services to enrollees with TPL when benefits are not available at the time claim is filed. When a claim is denied because an enrollee has not satisfied a third party deductible and/or copay requirement, then the claim should be processed by the MCO according to its usual procedures.

The MCO must deny payment on a claim that has been denied by a third party payer when the reason for denial is the Provider or enrollee's failure to follow proper procedures such as, a request for additional information, timely filing, etc.

The Provider may only ask the patient for any Healthy Connections Medicaid allowed copayment, even if the third party payer has a copayment requirement.

Upon request by Healthy Connections Medicaid, the MCO must demonstrate that reasonable effort has been made to seek, collect and/or report third party recoveries. Healthy Connections Medicaid shall have the sole responsibility for determining whether reasonable efforts have been demonstrated by the MCO.

For all cites in Section 10.4.5, please refer to the contract for all requirements between MCO and SCDHHS.

10.5 Post Payment Recoveries (Benefit Recovery Activities)

Section 10.5.1 through Section 10.5.2: There are times when the existence of a third party payer is not discovered until **after** a Provider claim has been paid. Providers have the discretion to refund payments they have received from the MCO, in order to pursue the third party payment, except in cases involving liability insurance. If a Provider receives payment from MCO and subsequently receives payment from the insurance company for the same date of service, the Provider must follow the MCO claims processing guidelines for void and replace or adjustment billing.

If the MCO learns of the existence of a third party payer **after** it has made a payment to the Provider, the MCO may recover its payment to the Provider or insurance company. If the third party payer is liability insurance, please see the description of casualty recoveries below. This does not affect the MCO recovery efforts due to a duplicate payment when both the MCO and a third party payer have paid a claim to the same Provider for the same service. Recovery categories include Retro Medicare, Retro Health, and Pay & Chase. The MCO should use an established billing cycle to recover expenditures for claims which should be covered by other third party resources. At the end of each month, the MCO claims database will search for claims which should have been covered by policies added during the month and also for claims which were not cost avoided.

Casualty recoveries function is to identify and recover monies paid on behalf of a Medicaid beneficiary for services resulting from any type of accident for which a third party is liable. Accident types include, but are not limited to, automobile, slip and fall, medical malpractice, and assault. Each MCO is required to pursue casualty recoveries just as they are required to pursue other types of TPL claims. However, SCDHHS shall retain the responsibility for handling any casualty claims that involve product liability, class action suits, multi-state litigation, and Special Needs Trusts. If an MCO is notified, or otherwise becomes aware of casualty claims involving product liability, class action suits, multi-state litigation, and/or a Special Needs Trust, the MCO is required to forward the claims to SCDHHS by the end of the next business day.

Accident questionnaires must be generated preferably automated using analysis of trauma diagnoses and surgical procedure codes. Beneficiaries are asked questions including but not limited to. "How did you get hurt?" Did you hire a lawyer? etc. Responses are investigated for possible casualty recovery and for indications of other health insurance.

Once a casualty case has been established, MCOs and/or their Contractors must comply with the requirements of Article 5 of Title 43 of the Code of Laws of South Carolina 1976, as amended. The MCOs and/or their Contractors must also comply with all the requirements Title 42, Part 433, Subpart D of the Code of Federal Regulations and all pertinent federal and state laws. Upon request by Health Connections Medicaid, the MCOs must demonstrate its compliance with these requirements.

Healthy Connections Medicaid expects letters to be sent to Providers or insurance companies requesting reimbursement of MCO payments for claims involving primary health insurance. Follow-up letters are automatically generated if refunds have not been made within ninety (90) days. Provider accounts may be debited by the MCO if refunds are not made. Denials of payment by insurance companies may be challenged by the MCO for validity and/or accuracy. Every attempt is made to satisfy plan requirements to ensure that Medicaid managed care payments and TPL payments are valid for each claim filed on behalf of a Medicaid member.

Section 10.5.3.1: Prior to recoupment of its payment, the MCO should notify the Provider and/or insurance company with a **refund request letter** that includes, at a minimum:

- The name of the MCO
- The name of the Provider
- The list of claims or a reference to a remit advice date
- Recipient name
- The reason the MCO considers the payment was made in error (commercial insurance responsible)
- The identification and contact information of the primary insurance carrier at the time of service

- A time period of at least forty-five (45) calendar days in which the Provider may reimburse the MCO's payment and /or appeal the decision
- Information on how to file an appeal
- A request that the Provider submit claims to the commercial insurance carrier or Medicare if not already done

When Providers choose to appeal the refund request letter from the MCO, they are given thirty (30) calendar days in addition to the forty-five (45) initial calendar days stated in the letter to provide sufficient documentation to the MCO prior to the MCO's recovery of their payment. Providers should include in their appeals a copy of a denial from the primary carrier, if available.

For all cites in Section 10.5.3.2 through Section 10.5.3.5, please refer to the contract for all requirements between MCO and SCDHHS.

10.6 Retroactive Eligibility for Medicare

Institutional and professional medical Providers should be invoiced as soon as the MCO becomes aware of the members retroactive Medicare coverage (Retro Medicare). A letter should be sent indicating that the Provider account will be debited. The letter should identify Medicare-eligible beneficiaries, dates of service, as well as the date of the automated adjustment and mechanism for identification of the debit(s).

Providers are expected to file the affected claims to Medicare within thirty (30) days of the MCO invoice. After filing a claim to Medicare, Providers have the option of filing a claim to Managed Care Organizations for consideration of any additional payment toward any applicable Medicare coinsurance and deductible. Requests for reconsideration of the debit must be received within 90 days of the debit. If Medicare has denied the claim, the Provider may submit a claim to Managed Care Organization for payment along with the Medicare denial.

Each procedure billed by the Provider should be individually assessed and the MCO's recovery process should not include procedure codes that are not Medicare covered.

10.7 Third Party Liability Reporting Disenrollment Requests

For all cites in Section 10.7, please refer to the contract for all requirements between MCO and SCDHHS.

10.8 Third Party Liability Recoveries by the Department

For all cites in Section 10.8, please refer to the contract for all requirements between MCO and SCDHHS.

10.9 Reporting Requirements

Section 10.9.1: MCO systems should support activities related to identification of third party resources, cost avoidance, collection and recovery of Title XIX expenditures from third party sources, posting of benefits recovered and federal reporting. Sections of the system should work together to accomplish and report the following objectives:

- Identify and maintain third party liability resources
- Identify and maintain third party carrier data
- Cost avoid claims as appropriate to avoid payment when third party carrier exist
- Report all payment avoided due to established third party liability
- Produce bills to Provider or carriers for recovery of payments made prior to identification of a third party resource
- Produce bills to Providers for retroactive Medicare eligible beneficiary's
- Account for receipts from Providers or carriers
- Produce accident questionnaires for designated trauma diagnosis codes and post the initial questionnaire to stop the production of a 2nd one.
- Track and follow-up on all automated TPL correspondence.

Section 10.9.2 through Section 10.9.2.1.4: MCOs must report submit three (3) TPL reports to SCDHHS on a monthly basis.

1. TPL verification Data: This report consists of all MCO beneficiaries that have been identified as having TPL coverage that SCDHHS has not identified as having TPL coverage. The report will be uploaded to the SCDHHS FTP site on a monthly basis.
2. Cost Avoidance Claims: This report consists of all claims during the month that have been identified as having third party coverage leading to cost avoidance by the MCO. This report should be broken into professional, institutional and pharmaceutical claim types. The report will be uploaded to the MCO's SharePoint monthly library and will contain the following data elements, Medicaid member ID, first name, last name, beginning date of service, ending date of service, claim paid date, paid Provider NPI, submitted charges, paid amount, TPL amount declared on claim, and amount cost avoided.
3. Recovery Claims: This report consists of all claims during the month that have been identified as having third party coverage leading to recoveries by the MCO. This report should be broken into professional, and institutional claim types. The report will be uploaded to the MCO's SharePoint monthly library and will contain the following data elements, Medicaid member ID, first name, last name, beginning date of service, ending date of service, claim paid date, paid Provider NPI, submitted charges, paid amount, date billed to carrier or Provider, and amount recovered.

11.0 Program Integrity

11.1 General (Contractor Program Integrity and Compliance Programs)

For all cites in Section 11.1, please refer to the contract for all requirements between MCO and SCDHHS.

11.2 CONTRACTOR Requirements

For all cites in Section 11.2.1 to 11.2.8.5, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.2.9 through Section 11.2.9.1: As stated in the contract the MCO must provide the toll-free fraud hotline phone number (1-888-364-3224) and fraud email address (fraudres@scdhhs.gov) in all employee handbooks, provider manuals, mass communications, and on the MCO website. Member communications are further defined in this guide as mass mailings including but not limited to member newsletters, benefit change notifications, or any other distribution affecting large segments of the MCO membership.

For all cites in Section 11.2.10, please refer to the contract for all requirements between MCO and SCDHHS.

11.3 Contractor Subcontracting Review and Approval Procedures

Section 11.3.1 through Section 11.3.3: please refer to the contract for all requirements between MCO and SCDHHS.

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

Section 11.4.1 through Section 11.4.11: Preliminary Investigation of and Reporting Suspected Fraud and Abuse

In accordance with its own Program Integrity and Compliance Plan, the MCO shall promptly perform a preliminary investigation of all complaints and allegations of suspected fraud and abuse on the part of the Providers or members in the Plan. Such complaints and allegations can come from any source, including the results of the MCO's own surveillance and utilization review (SUR) or data mining activities. If a complaint or the findings of a preliminary investigation give the MCO reason to suspect that fraud or abuse of the Medicaid program has occurred, whether by a Provider or a member, the MCO must report this information to the SCDHHS Division of Program Integrity (PI) immediately (within one [1] business day). The MCO must complete the appropriate Fraud and Abuse Referral Form for Managed Care Organizations (see the Operating Companion Guide for the Fraud and Abuse Referral Form) located on the PI Share Point site. After completing the form in Share Point, the form will be transmitted

by using the SUBMIT button. An email is necessary to the PI Coordinator notifying them of the transmittal. These complaints will be logged by the SCDHHS Intake Worker.

Any suspicion or knowledge of fraud and abuse would include, but not be limited to, the false or fraudulent filings of claims, the provision of services that were not medically necessary, and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent, on the part of members, employees, Providers, or subcontractors. Potential fraud on the part of a Provider would include either participating or non-participating Providers in the MCO's plan.

Fraud and Abuse Indications

The MCO must conduct a preliminary investigation and report the suspected fraud and abuse when any of the following indications are present:

A. For Providers/Subcontractors:

- There is no documentation for services, which means the entire patient record for the encounter is missing or vital aspects of the record are missing or incomplete. "Vital aspects" of the medical could include but are not limited to service notes, prior authorization or medical necessity statements, appropriate reports when diagnostic services are billed, or any other documentation that establishes the scope, duration and medical necessity for the service provided.
- Billing for services, supplies or equipment that are not rendered or used for Medicaid members
- Evidence of manufactured or altered documentation or forged signatures
- The Provider has engaged in unallowable marketing and/ or recruitment of patients
- An excluded/terminated individual, or a Provider not enrolled or contracted with a plan, is using another Provider's NPI in order to be paid
- Material misrepresentation of dates and descriptions of services rendered, the identity of the individual rendering the services, or the recipient of the services
- Excessive costs and number of claims
- Billing an unreasonable or improbable number of units or services (Time Bandit)
- Billing an unreasonable or excessive amount of supplies, or supplies and equipment clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless
- Procedure codes/ services do not correspond with Provider type
- Procedure code/services/number of units are not supported by member's diagnosis

- There are repeated patterns of up-coding and/or unbundling or other behavior that result in a large overpayment to the Provider
- There are unexplainable, significant spikes in claims volumes and reimbursement
- Billing for numerous diagnostics, “special studies” and exotic tests with no documentation for medical necessity
- Other indications of fraud that should be described by the Plan making the referral.

B. For Members:

- Suspicion that he or she submitted a false application for Medicaid
- Provided false or misleading information about family group, income, **assets and/or resources or any other information in order to fraudulently** gain eligibility for benefits
- Shared or lent their Medicaid card to other individuals
- Sold or bought a Medicaid card
- Diverted for re-sale prescription drugs, medical supplies, or other benefits
- Obtained Medicaid benefits that they were not entitled to through other fraudulent means.

MCO Responsibilities

The MCO shall promptly provide the results of its preliminary investigation to SCDHHS, using the Fraud and Abuse Referral Forms for Managed Care Organizations (see the Operating Companion Guide for the Fraud and Abuse Referral Form) located on the PI Share Point site. After completing the form in Share Point, the form will be transmitted by using the SUBMIT button. The MCO Compliance Officer must email the PI Coordinator notifying them of the transmittal. These complaints will be logged by the SCDHHS Intake Worker.

The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview MCO’s 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. The MCO may be asked to perform an audit to determine its losses. This information should be provided judiciously.

Unless prior written approval is obtained from SCDHHS Division of Program Integrity, after reporting the suspected Provider fraud and/or abuse, the MCO shall suspend its

investigation and not take any of the following actions as they specifically relate to Medicaid managed care claims:

- Request medical records or contact the subject of the allegation.
- Enter into or attempt to negotiate any settlement or agreement regarding the incident;
- Accept any monetary or other thing of valuable consideration offered by the subject of the investigation in connection with the incident;
- Alter or allow alteration of any claims that are part of an investigation.

Regardless of the fraud referral to SCDHHS, the MCO 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.

If a member is referred for suspicion of fraud or abuse, the MCO is under no further obligation to investigate or open a case. Member fraud is pursued entirely by SCDHHS in conjunction with the South Carolina State Attorney General's Office under specific contractual provisions.

SCDHHS Responsibilities

SCDHHS PI Coordinator will acknowledge receipt of the Provider or member fraud referral form within five (5) working days by responding to the MCO Compliance Officer's transmittal email. PI will work closely with the MCO's compliance and SIU staff to determine as quickly as possible whether a fraud referral to the South Carolina Attorney General's Office, Medicaid Fraud Control Unit (MFCU), is warranted.

SCDHHS will review and evaluate the referral and any documentation from the MCO's preliminary investigation, and at its discretion, may:

- Immediately send the fraud referral onto the MFCU or Medicaid Recipient Fraud Unit,
- Conduct additional investigation and research into the matter,
- Open its own case, and/or
- Return the referral to the MCO to pursue through its own administrative actions.

SCDHHS will inform the MCOs as well as the Division of Care Management when cases against Providers and members in the managed care program are referred by SCDHHS to the South Carolina Attorney General's Office for fraud, as well as when the case results in a criminal conviction, exclusion, and/or termination.

SCDHHS may elect not to accept a fraud or abuse referral from an MCO if:

- It contains insufficient information, in which SCDHHS will send the case back to the MCO for development of the required components;

- The potential losses due to fraud or abuse are under a specified dollar amount; or
- The circumstances do not warrant any sanctions other than Provider education and/or pre-payment review.

For referrals from the MCOs accepted by SCDHHS, SCDHHS takes full responsibility for ensuring the appropriate referral, investigation and conclusion of the case, as well as the termination or exclusion of Providers convicted of fraud.

Coordination Involving SCDHHS Fraud Hotline Complaints

When the SCDHHS Fraud Hotline, Division of Program Integrity, Department of Recipient Utilization, receives a complaint about an MCO beneficiary/member, the complaint is entered into the Hotline Complaint Log within one working day and researched by the Recipient Utilization intake worker.

The Department of Recipient Utilization will capture data about complaints made against beneficiaries receiving services under a managed care plan.

Provider Audits and Reviews

The MCOs and the SCDHHS Division of Program Integrity will collaborate on Provider program integrity reviews as much as possible. The collaboration may involve data sharing and joint review of Providers that provide Medicaid services in both fee-for-service and managed care environments.

Program Integrity can pull both fee-for-service and encounter data into its reviews. The MCOs will provide any information needed by Program Integrity for Provider reviews, including but not limited to copies of Provider sub-contracts, Provider manuals, policies and procedures, fee schedules, and credentialing files.

1. Cases of suspected Provider fraud and abuse that are referred from the MCOs to Program Integrity but which do NOT result in a fraud referral to the Medicaid Fraud Control Unit, will be worked in the following manner:
 - If Program Integrity does NOT already have an open complaint or case on the Provider in question, Program Integrity will review the fee-for-service claims data for the Provider under all applicable NPIs and/or Medicaid legacy ID numbers.
 - Depending on the programmatic/clinical issues involved and the volume of fee-for-service claims, Program Integrity will refer the case back to the MCO and/or will open its own case on the Provider.
 - If Program Integrity opens its own case, Program Integrity will proceed with its normal review process and pull the sample of claims from both the fee-for-service and managed care payment environments.

- The MCO will coordinate its own review of the Provider with Program Integrity to make sure the same claims are not being reviewed under both programs.
 - If Program Integrity already has an open complaint or case on the Provider or has scheduled that Provider for review based on data mining results, it will review the issues involved with the referral.
 - This will include any Providers under review or scheduled for review by the Program Integrity Recovery Audit Contractor.
 - Depending on the issues and claims volume involved, Program Integrity will either ask the MCO to continue to suspend its own investigation or will refer the managed care side of the case back to the MCO for its own actions.
 - Once its review is finished, Program Integrity will provide copies of any findings and the identified overpayment to the MCO(s) involved.
 - In all cases there will be close and on-going communication between the SCDHHS Program Integrity reviewer and the MCO SIU unit, and PI will report to the MCO on the progress/outcomes of these cases during quarterly meetings.
2. For cases involving a managed care Provider that Program Integrity initiates, either through a complaint, data mining, or other reason, Program Integrity will review according to its normal policies and procedures.
- If during the course of this review Program Integrity identifies potential overpayment and billing issues with the Provider's encounter (managed care) claims, Program Integrity can:
 - Refer those claims to the MCO for action; and/or
 - Continue with its own review until it is concluded.
 - In all cases Program Integrity will coordinate closely with the MCO(s) involved and provide copies of any findings and the identified overpayment that involve encounter claims.
3. When Program Integrity identifies improper billing that could result in an overpayment made to a Provider from a managed care organization, regardless of the reason for the overpayment or the source of the case, it shall furnish all relevant information about the overpayment to the MCO for the MCO's validation. PI may also ask the MCO to expand the review if the overpayment was estimated based on a sample.

Once the MCO has validated the overpayment and/or completed its expanded review, it shall afford the Provider a chance to ask for reconsideration or to appeal its findings in accordance with the MCO's current policy.

Once the time frame for timely filing of the appeal is over or any appeals proceedings have run their course, the MCO should take action within thirty (30) days to recover the overpayment from the Provider. If the MCO cannot or will not take action to recover the overpayment, the reason for this must be provided to Program Integrity in writing. All overpayments identified and recovered by the MCOs as an audit, investigation, or integrity case must be reported in the quarterly Fraud and Abuse report.

Beneficiary Explanation of Medical Benefits (BEOMB)

The SCDHHS Division of Program Integrity (PI) administers the Beneficiary Explanation of Medical Benefits Program (BEOMB) program. This program, which is required by 42 CFR 433.116, gives beneficiaries the opportunity to participate in the detection of fraud and abuse. A letter is sent to approximately four hundred, randomly selected beneficiaries each month that lists all non-confidential services that were paid during the preceding month. Generated BEOMBs include Fee-for-Service and Managed Care Services. Beneficiaries are requested to verify that they received the services and may be asked three additional questions about their pharmacy services. A stamped self-addressed envelope is provided for their response.

When a beneficiary in a Managed Care plan returns a BEOMB with the assertion that some or all the MCO-covered services were not received, PI Coordinator will upload to the PI Share Point site the BEOMB letter and the BEOMB Referral Form to the appropriate Plan(s) involved. The PI Coordinator will also email the MCO Compliance Officer notifying them of the transmittal. The MCO must conduct a preliminary investigation to determine whether the services were provided as reported in the encounter. If the MCO finds any indication of fraud or abuse, it will forward the BEOMB issue to Program integrity, using the Fraud and Abuse Referral Form for Managed Care Organizations (see Fraud and Abuse Referral Form in Operating Companion Guide).

11.5 Recoveries and Provider Refunds

Payment Suspension in Cases of a Credible Allegation of Fraud

In cases where SCDHHS suspends a Provider's payments due to a credible allegation of fraud, it will also direct any MCO(s) who subcontract with the Provider to likewise suspend that Provider's payments. A "credible allegation of fraud" is an allegation that has been verified by SCDHHS and that comes from any source, including but not limited to the following:

- Fraud hotline complaints (including those made by the MCO(s))
- Claims data mining
- Patterns identified through Provider audits, civil false claims cases, and law enforcement investigations.

SCDHHS has flexibility in determining what constitutes a “credible allegation of fraud.” Allegations are considered to be credible when they have indications of reliability based upon SCDHHS’ review of the allegations, facts, and evidence on a case-by-case basis.

Notice of Suspension

SCDHHS will notify all MCO(s) to suspend all Medicaid payments to the Provider after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against the Provider, either as an individual or entity. Suspension of payment must be completed within five (5) business days of receiving the notification from SCDHHS to suspend payment. Payments may be suspended without first notifying the Provider of the intention to suspend payments. The MCO will send notice of its suspension of program payments within the following timeframes:

- Within five (5) business days of suspending the payment, unless requested in writing by a law enforcement agency to temporarily withhold such notice.
- Within thirty (30) calendar days of suspending the payment, if requested by law enforcement in writing to delay sending such notice.
- The Notice of Payment Suspension will include all information required to be provided in accordance with 42 CFR §455.23.

All suspension of payment actions will be temporary and will not continue after either of the following:

- SCDHHS or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider.
- Legal proceedings related to the Provider’s alleged fraud are completed.

Good Cause Not to Suspend Payments or to Suspend Only in Part

The MCO may find that good cause exists not to suspend payments, or not to continue a payment suspension previously imposed on an individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- Law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.
- Other available remedies implemented by the MCO will more effectively or quickly protect Medicaid funds.
- The MCO and SCDHHS jointly determine, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, that the suspension should be removed.

- The MCO and SCDHHS determine that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons:
 1. An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
 2. The individual or entity serves a large number of beneficiary's within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- Law enforcement declines to certify that a matter continues to be under investigation.
- The MCO and SCDHHS jointly determine that payment suspension is not in the best interests of the Medicaid program.

The MCO and SCDHHS may also find that good cause exists to suspend payments in part, or to convert a payment suspension previously imposed in whole to one only in part, on any individual or entity regarding a credible allegation of fraud, if any of the following are applicable:

- The MCO and SCDHHS jointly determine that beneficiary access to items or services would be jeopardized by a payment suspension for either of the following reasons.
 1. An individual or entity is the sole community physician or the sole source of essential specialized services in a community.
 2. The individual or entity serves beneficiary's within a medically underserved area, as designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.
- The MCO and SCDHHS jointly determine, based upon the submission of written evidence by the individual or entity that is the subject of a whole payment suspension, that such suspension should be imposed only in part.
- The MCO and SCDHHS jointly determine the following:
 1. The credible allegation focuses solely and definitively on only a specific type of claim or arises from only a specific business unit of a Provider; and
 2. A payment suspension in part would effectively ensure that potentially fraudulent claims were not continuing to be paid. If this determination is made, it will be documented in writing by the MCO.
- Law enforcement declines to certify that a matter continues to be under investigation.
- The MCO and SCDHHS jointly determine that payment suspension is not in the best interest of the Medicaid program.

Release of Payments

Once SCDHHS or the prosecuting authorities determine that there is insufficient evidence of fraud by the Provider, and/or legal proceedings related to the Provider's alleged fraud are completed, the MCO's must release the withheld payments back to the Provider and/or apply the suspended payments to any outstanding Provider debit. SCDHHS will inform the MCOs when any suspended payments can be released.

Payment Suspension in Cases of Fraud

When SCDHHS forwards a referral from an MCO to the MFCU for suspected Provider fraud, it will immediately suspend any fee-for-service payments to the Provider in accordance with federal regulations and SCDHHS policy, unless directed otherwise by the MFCU. SCDHHS will immediately inform the MCOs involved when the Provider's fee-for-service payments are suspended. The MCO(s) must take similar action to suspend managed care payments to a Provider in its network that has been referred for fraud (see Reporting Requirements - Suspension of Payments). This requirement is in response to new regulations at 42 CFR 455.23.

Settlements and Restitution

SCDHHS shall retain all recoveries resulting from fraud and abuse cases pursued by SCDHHS and MFCU for managed care Provider fraud referrals that end in a financial settlement or restitution negotiated by the MFCU.

In accordance with current practice, SCDHHS will receive the fraud recoveries from the Provider either through the MFCU or through the court system.

11.6 Reporting Requirements for Program Integrity

SCDHHS provides a SharePoint site via the Internet for the individual MCOs to use for sharing beneficiary/member and Provider information in the context of fraud and abuse reviews and referrals. The Program Integrity Coordinator will assist in establishing a connection and a password for the Plans to use to upload or download data.

- If a complaint or the findings of a preliminary investigation give the MCO reason to suspect that fraud or abuse of the Medicaid program has occurred, whether by a Provider or a member, the MCO must report this information to the Division of Program Integrity immediately (within one (1) business day) by completing the Provider Fraud Referral Form (see the Operating Companion Guide for the Fraud and Abuse Referral Form) located on the PI SharePoint site and submitting thru that site.
- Any documentation attachments, especially if they are voluminous or contain PHI, should be uploaded under Documents on the PI SharePoint site.
- Member Fraud Referral Forms (see the Operating Companion Guide for the Fraud and Abuse Referral Form) located on the PI SharePoint site should be completed and submitted through that site.

- The Monthly and Quarterly Fraud and Abuse reports are housed and generated in the PI SharePoint site.
- The MCOs are responsible for providing and updating the Division of Program Integrity with the names, email addresses and other contact information of the Compliance and/or other MCO staff who will be using the PI SharePoint site.

Monthly Fraud and Abuse reports

All MCOs must submit a Monthly Fraud and Abuse Activities Report. SCDHHS will provide a reporting format with detailed instructions and data definitions (see Monthly Fraud and Abuse Activities Report in Operating Companion Guide). The report must be generated and maintained on the PI Share Point site. The report will include:

- The MCO's open Program Integrity Provider cases, showing Provider name, date opened, status, and the complaint or the allegation. "Program Integrity Provider cases" means any Provider under review by the MCO, including:
 - Providers that are the subject of preliminary Investigations, including any investigations that are initiated through a REOMB response
 - Providers referred to SCDHHS on the Fraud and Abuse Referral For.
 - Audits Performed by the MCO; this would include Recovery Audit Contractor audits, pharmacy audits, etc.
 - Providers identified through exception reports or fraud algorithms conducted by the MCO SI.
- The amount of funds "at risk" because of the Providers listed above.
- Overpayment amounts determine.
- Information about the review or audit period and dates the cases were opened or closed, etc.
- Members referred upon suspicion of eligibility fraud on the Member Fraud and Abuse Referral For.

The monthly fraud and abuse activities report will be generated from Share Point on the 15th of the following month, if the 15th falls on a weekend or a State holiday, it must be generated the following work day. For example, the report of October's activities would be generated on November 15th.

Quarterly Reporting

The MCOs must also provide a quarterly report that will be based on the monthly reports and show outcomes or results of the MCO's program integrity efforts. This will include the amount of overpayments recovered and whether the MCO had applied any sanctions to Providers as a result of Program Integrity activities. The MCOs will be provided with detailed instructions and a reporting format for this information (see Quarterly Fraud and Abuse Report in Operating Companion Guide). The quarterly

reports are due no later than thirty (30) days after the end of each quarter: April 30th; July 30th; October 30th; and January 30th and will be uploaded to the appropriate folder on the Share Point site.

The MCO Compliance Officers/SIU shall meet at least quarterly with SCDHHS staff from Program Integrity/SURS, within 2-3 weeks after the Quarterly report is due. In addition, the MCO's SIU/Compliance/Program integrity staff should meet or confer with SCDHHS Program Integrity as often as needed on joint cases and Fraud and Abuse referrals.

In accordance with the Affordable Care Act and SCDHHS policy and procedures, the MCO shall report overpayments made by SCDHHS to the MCO as well as overpayments made by the MCO to a Provider and/or subcontractor.

SCDHHS Reporting of Exclusions and Terminations for Cause

The SCDHHS Division of Program Integrity will provide notice of all Provider exclusions, terminations for cause, and reinstatements to the Managed Care Organizations and forward a copy to the Division of Care Management. Provider exclusion and termination for cause actions will be based on fraud convictions, loss of license, patient abuse, and other reasons as specified in the SCDHHS Medicaid Provider Enrollment Manual. Reinstatement letters will indicate Provider removal from the SCDHHS exclusion list. Once a Provider is removed from the exclusion list, he or she must reapply to become a Medicaid Provider; it is not automatic. (**Note:** SCDHHS updates its website regularly with names of excluded individuals and entities. The MCOs should use this website for on-going information about exclusions.)

In addition to providing this information in the quarterly reports, the MCOs will report this on a monthly basis and will be provided with detailed instructions and a reporting format for this information (see Quarterly Fraud and Abuse Report in Operating Companion Guide). The MCOs must also use the Fraud and Abuse Referral Form for Managed Care Organizations for reporting managed care Provider Terminations For Cause. This form must be provided to SCDHHS within five (5) business days of the Provider's effective date of termination from the MCO's network.

When PI excludes or terminates a provider, PI will notify all of the MCO's Compliance Officers via email regarding the exclusion or termination. PI will then update the DHHS Exclusions or DHHS Terminations files located in SharePoint with the provider's information. PI will also post the Provider Exclusion or Termination Letter in the DHHS Prov Letter folder. The MCOs will respond to PI's actions by also updating the DHHS Exclusions or DHHS Terminations files with the actions they have taken against the provider. The MCOs can view PIs letter to the provider in the DHHS Prov Letter folder. If the MCO also terminate, they will upload a copy of their letter to the provider in the Termination Letters folder on their individual site.

Suspension of Payments

When PI suspends a provider's payments for a credible allegation of fraud, PI will notify all of the MCO's Compliance Officers via e-mail regarding the suspension. PI will then update the DHHS Suspensions file located in SharePoint with the provider's information. PI will also post the Provider Suspension Letter in the DHHS Prov Letter folder. The MCOs will respond to PI's actions by also updating the DHHS Suspensions file with the actions they have taken against the provider. The MCOs can view PI's letter to the provider in the DHHS Prov Letter folder. If the MCO also suspends the provider, they will upload a copy of their letter to the provider in the Suspension Letters folder on their individual site.

11.7 Ownership and Control

Section 11.7.1 through 11.7.1.1: Subcontractors shall disclose to the MCO information related to ownership and control, significant business transactions, and persons convicted of crimes as required under the SCDHHS Contract, SCDHHS Policy and Procedure Guide, and 42 CFR §§ 455.104, 455.105 and 455.106 (2009, as amended). Such information shall be disclosed on the SCDHHS Form 1514 and/or such other format as may be required by SCDHHS or CMS. Subcontractors must report any changes of ownership and disclosure information at least thirty (30) calendar days prior to the effective date of the change.

Additionally, the MCO must submit, within thirty (30) calendar days of request by SCDHHS, full and complete information about any significant business transactions between the MCO and Subcontractor(s) and any wholly owned supplier, or between Subcontractor and any of its Subcontractor(s) during the five-year (5) period ending on the date of the request. A "significant business transaction" means any business transaction or series of transactions during any month of the fiscal year that exceeds the lesser of \$25,000 or 5% of the Subcontractor's total operating expenses.

MCOs are required to utilize the new version of the Ownership Disclosure Form (1514) for all Providers. MCOs are required to have all subcontractors fill out an ownership disclosure form prior to execution of the contract (agreement). Additionally, MCOs must verify the Subcontractor's information at least yearly based on the date of execution of the contract (agreement).

All information, including the form, must be kept in the MCOs files. After verification by the MCO, if it is discovered the Subcontractor/staff/owners/board members, or any of its Subcontractors/staff/owners/board members are on the Excluded Provider List, the MCO must immediately report the information to SCDHHS and terminate the contract.

11.8 CONTRACTOR Providers and Employees – Exclusions, Debarment, and Terminations

For all cites in Section 11.8, please refer to the contract for all requirements between MCO and SCDHHS.

11.9 Prohibited Affiliations with Individuals Debarred by Federal Agencies

For all cites in Section 11.9, please refer to the contract for all requirements between MCO and SCDHHS.

11.10 Provider Termination/Denial of Credentials

Section 11.10.1 through Section 11.10.4: When the SCDHHS Division of Program Integrity takes action to exclude or to terminate a Provider for cause, or to reinstate a Medicaid Provider's billing privileges, the Providers are informed of these actions through a letter sent certified mail. The agency will send copies of all Provider notification letters to the Compliance Officers for each Plan, and this will serve as the notification to the MCOs of the action. "Exclusion" means that items or services furnished by a specific Provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid or any Medicaid managed care program. Provider exclusions can be based on fraud convictions, loss of license, patient abuse, and other reasons. MCOs cannot employ Providers who have been debarred, suspended, or excluded from Medicare and Medicaid. Also, SCDHHS updates its website monthly with names of excluded individuals and entities. In addition to checking the LEIE, the MCOs should use this website for on-going information about exclusions.

Reinstatement letters will indicate Provider removal from the SCDHHS exclusion list. Once a Provider is removed from the exclusion list, he or she must reapply to become a Medicaid Provider; it is not automatic.

"Termination" means SCDHHS 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 expectation on the part of the Provider or SCDHHS that the revocation is temporary. Provider termination for cause is based on SCDHHS Provider enrollment policies found in the Provider Enrollment Manual at <https://www.scdhhs.gov/provider-type/provider-enrollment-manual>. There are multiple reasons why SCDHHS can terminate a Provider for cause.

MCOs are required to report to SCDHHS Program Integrity, via the Fraud Referral Form for Providers, action taken by the MCO to terminate a Provider for cause; e.g., fraud, abuse, or loss of credentialing privileges.

11.11 Information Related to Business Transactions

For all cites in Section 11.11, please refer to the contract for all requirements between MCO and SCDHHS.

11.12 Information on Persons Convicted of Crimes

For all cites in Section 11.12, please refer to the contract for all requirements between MCO and SCDHHS.

12.0 Marketing Program

12.1 General Marketing Requirements

The MCO shall be responsible for developing and implementing a written Marketing/advertising plan designed to provide the Medicaid MCO Member with information about the MCO's Managed Care Plan. The Marketing plan shall include details identifying the target audiences, marketing strategies to be implemented, marketing budget, and expected results. Also included will be the various events in which the MCO expects to participate.

All Marketing/advertising and Medicaid MCO beneficiary education Materials must contain the South Carolina Healthy Connections logo, and the MCO's Member Services toll-free number. The Marketing/advertising plan and all related accompanying materials are governed by 42CFR § 438.104 and the information contained within this P&P Guide. Should an MCO require additional guidance or interpretation, it should consult with the SCDHHS.

SCDHHS defines Marketing/media Materials as those materials that:

1. Target existing or potential Providers and/or Medicaid MCO Members, which are produced via any medium by, or on behalf of an MCO; or
2. Materials that SCDHHS interprets as being produced with the intent to market to existing or potential Providers and/or Medicaid MCO Members.

Marketing/advertising and educational Materials/media include, but are not limited to the following:

- Brochures
- Fact sheets
- Posters
- Videos
- Billboards
- Banners
- Signs
- Commercials (radio and television ads/scripts)
- Print ads (newspapers, magazines)
- Event signage
- Vehicle coverings (buses, vans, etc.)
- Internet sites (corporate and advertising)
- Social Media sites (such as, but not limited to Facebook, Twitter, blogs)

- Other advertising media as determined by SCDHHS

Member education is educational activities and materials directed at Medicaid MCO beneficiaries that increases the awareness and favorably influences the attitudes and knowledge relating to the improvement of health on a personal or community basis. Medicaid MCO beneficiary education also includes information and materials that inform the Medicaid MCO beneficiary on the MCO's Policies, procedures, requirements and practices.

Marketing activities include, but are not limited to, distribution of Marketing and advertising Materials; health plan promotion, including attendance of community, business and other events; and, any other means of calling public attention to the Medicaid Managed Care Plan or company.

12.2 Prior Approval of Marketing Materials

For all cites in Section 12.2, please refer to the contract for all requirements between MCO and SCDHHS.

For all cites in Section 12.2.2, please see Marketing guidelines below.

For all cites in Section 12.2.3 through Section 12.2.3.1, please refer to the contract for all requirements between MCO and SCDHHS.

12.3 Guidelines for Marketing Materials and Activities

Section 12.3.1: All SCDHHS Marketing/advertising and Medicaid MCO Member education Policies and procedures stated within this guide apply to staff, agents, officers, Subcontractors, volunteers, and anyone acting for or on behalf of the MCO.

Violation of any of the listed policies shall subject the MCO to sanctions, including suspension, fine and termination, as described in the contract between SCDHHS and the MCO. The MCO may appeal these actions within 30 calendar days in writing to the SCDHHS' Appeals Department.

The MCO's Marketing/advertising plan shall guide and control the actions of its Marketing staff. In developing and implementing its plan and materials, the MCO shall abide by the following Policies:

A. Permitted Activities

1. The MCO is allowed to offer nominal "give-a-way items that cannot have a fair market value of more than \$10.00; with such gifts being offered regardless of the Beneficiary's intent to enroll in a plan. Cash gifts of any amount, including contributions made on behalf of people attending a Marketing event, gift certificates or gift cards, alcohol, tobacco, ammunition, and weapons are not permitted to be given to Beneficiaries or the general public.

2. The Marketing representative is responsible for providing the Medicaid MCO Member with information on participating PCPs and assisting in determining if his or her current physician is a member of the MCO's network.
3. The Marketing representative is responsible for providing the Medicaid MCO Member with information on participating PCPs and assisting in determining if his or her current physician is a member of the MCO's network.
4. Any claims stating that the MCO is recommended or endorsed by any public or private agency or organization, or by any individual must be prior approved by SCDHHS and must be certified in writing by the person or entity that is recommending or endorsing the MCO.
5. The MCO is allowed to directly and/or indirectly conduct Marketing/advertising activities in a doctor's office, clinic, pharmacy, hospital or any other place where healthcare is delivered, with the written consent of the Provider. This also includes government facilities, such as local offices of the South Carolina Department of Health and Human Services, the Department of Social Services, the Department of Health and Environmental Control, Head Start and public schools. The use of government facilities is only allowed with the written permission of the government entity involved. Any stipulations made by the Provider or government entity must be followed (allowable dates, times, locations, etc.).
6. All Marketing/advertising activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of Beneficiaries or the general community.
7. The MCO may provide approved Marketing/advertising and educational Materials for display and distribution by Providers. This includes printed material and audio/video presentations.
8. Upon request by a Medicaid Beneficiary, Marketing representatives may provide him or her with information (excluding an enrollment form) about the MCO to give to other interested Medicaid Beneficiaries (i.e., business card, Marketing brochure).

B. Activities Which Are Not Permitted

1. The MCO is prohibited from distributing enrollment forms or aiding a Medicaid Beneficiary in filling out or transmitting an Enrollment form in any way.
2. When conducting Marketing/advertising activities, the MCO shall not use their personal or Provider-owned communication devices (i.e., telephone or cell phone, fax machine, computer) to assist a person in enrolling in a health plan.
3. The MCO shall not make any claims or imply in any way that a Medicaid Beneficiary will lose his or her benefits under the Medicaid program or any other health or welfare benefits to which he/she is legally entitled, if he/she does not enroll with the MCO.
4. The MCO cannot make offers of material or financial gain (such as gifts, gift certificates, insurance policies) to Medicaid Beneficiaries to induce plan Enrollment.

5. The MCO (and any Subcontractors or representatives of the MCO) shall not engage in Marketing/advertising practices or distribute any Marketing/advertising Materials that misrepresent, confuse, or defraud Medicaid Beneficiaries, Providers, or the public. The MCO shall not misrepresent or provide fraudulent misleading information about the Medicaid program, SCDHHS and/or its policies.
6. The MCO cannot discriminate on the basis of a Medicaid MCO Member health status, prior health service use or need for present or future healthcare services. Discrimination includes, but is not limited to, expulsion or refusal to re-enroll a Medicaid MCO Member except as permitted by Title XIX.
7. The MCO's Marketing representatives may not solicit or accept names of Medicaid Beneficiaries from Medicaid Beneficiaries or Medicaid MCO Member for the purpose of offering information regarding its plan.
8. The MCO may only market in the Beneficiary's residence if they obtain a signed statement from the Medicaid Beneficiary; giving permission for the MCO's representative to conduct a home visit for the sole purpose of Marketing activities.
9. The MCO is prohibited from comparing their organization/plan to another organization/plan by name.

C. Medicaid Beneficiary and MCO Member Contact

1. The MCO is not allowed to directly or indirectly, conduct door-to-door, telephonic, or other "cold call" Marketing/advertising activities. This includes initiating contact with a Medicaid MCO Member of the public or Beneficiary at a Marketing event.
2. The MCO is not allowed to initiate direct contact (defined as a face-to-face interaction where communication takes place) with Medicaid Beneficiaries for purposes of soliciting Enrollment in their plan.
3. The MCO may not market directly to Medicaid applicants/Beneficiaries in person or through direct mail advertising or telemarketing.
4. The MCO may contact Medicaid MCO Members who are listed on their monthly Medicaid MCO Member listing to assist with Medicaid recertification/eligibility.
5. The MCO is not allowed to directly, indirectly or use a third party vendor, contact Disenrollees listed on their monthly Medicaid MCO Member listing.

Beneficiary Marketing and Member Education Materials/Media

Marketing may include providing informational materials to enhance the ability of the Medicaid Beneficiary to make an informed choice of Medicaid managed care options. Such material may be in different formats (brochures, pamphlets, books, videos, and interactive electronic media).

The SCDHHS and/or its designee will only be responsible for distributing general Marketing/advertising Material developed by the MCO for inclusion in the SCDHHS Enrollment package to be distributed to Medicaid Beneficiaries. The SCDHHS at its sole discretion will determine which materials will be included.

The MCO shall be responsible for developing and distributing its own Beneficiary Marketing and advertising and Medicaid MCO Member education Materials. The MCO shall ensure that all Medicaid managed care Marketing/advertising and education Materials, brochures and presentations clearly present the core benefits and approved expanded benefits, as well as any limitations.

SCDHHS has established the following requirements for the MCO's Medicaid managed care Marketing/advertising and education Materials:

- MCOs can, with SCDHHS written prior approval, utilize mass media which includes, but is not limited to, public service announcements such as radio and television spots (air time paid for by MCO), advertising in newspapers, magazines, church bulletins, billboards, and buses.
- All Marketing/advertising Materials/media (including Internet and social media sites) must include the SC Healthy Connections (SCHC) logo, either color or black and white logo materials can be utilized.
- Promotional Materials to include items identified as “give-a-ways,” which contain the MCO’s logo must also contain the SCHC logo.
- Educational Materials and third party publications, such as CDC guidelines, dietary information, Disease Management, etc. do not require the SCHC logo so long as the MCO’s name, logo and/or phone number are not present. If the MCO logo and/or phone number is present, the SCHC logo must also be present.
- All logos (SCHC and MCO) and associated phone numbers must be proportional in size and location.
- MCOs can passively distribute approved Marketing/advertising and educational Materials, with written authorization from the entity responsible for the distribution site, to Medicaid Beneficiaries and Medicaid MCO Members. Passive distribution is defined as the display of materials with no MCO Marketing or education staff present.
- MCOs may mail SCDHHS approved Marketing/advertising and educational Materials within its approved Service Areas. Mass mailings directed to only Medicaid Beneficiaries are prohibited
- MCOs’ network Providers can correspond with beneficiaries concerning their participation status in the Medicaid Program and the MCO. These letters may not contain MCOs’ Marketing/advertising/education Materials or SCDHHS Enrollment forms. Letters must be developed, produced, mailed and/or distributed directly by the network Provider’s office at their expense. This function cannot be delegated by the Provider, to the MCO or an agent of the MCO. In addition, the use of these letters must be in accordance with SC Department of Insurance Policies and regulations.

- The MCO shall ensure that all materials are accurate, are not misleading or confusing, and do not make material misrepresentations.
- All materials shall be submitted to be reviewed and approved for readability, content, reading level, and clarity by SCDHHS or its designee, prior to use or distribution.
- The MCO shall ensure that all written material will be written at a grade level no higher than the sixth (6th) grade (6.9 on the reading scale) or as determined appropriate by SCDHHS.
- The MCO shall ensure that appropriate foreign language versions of all Marketing/advertising and education Materials are developed and available to Medicaid Beneficiaries and Medicaid MCO Members. Foreign language versions of materials are required if the population speaking a particular foreign (non-English) language in a county is greater than five percent (5%) percent. If counties are later identified, SCDHHS will notify the MCO. These materials must be approved, in writing, by SCDHHS. Affidavits of accuracy and reading level compliance by a professional translation service must accompany all foreign language translations and be submitted with the approval request.
- The MCO shall issue and mail a Medicaid MCO Member handbook which describes/contains at a minimum, the following:

Marketing Events and Activities

Written notice to SCDHHS is required prior to MCOs conducting, sponsoring or participating in Marketing/advertising activities. Written approval from SCDHHS is not required; however, should any activity be denied by SCDHHS, written notice of the denial must be forwarded to the plan via email.

Notification of all activities must include the date, time, location, and details of the MCO's activities. Notification must be made to SCDHHS no later than noon (12 PM Eastern Time), three (3) full business days prior to the scheduled event, excluding the date notification was sent. South Carolina state holidays are excluded from being counted as a business day. *[i.e., if a marketing event is on Friday the 15th, the notification to SCDHHS must be sent no later than noon (12 PM ET) Monday the 11th. Using the same example, if a state holiday is scheduled on Wednesday the 13th, the notification must be sent by noon (12 PM ET) no later than Friday the 8th.]*

When conducting Marketing activities, the MCO may not initiate contact with members of the public or Beneficiaries. They may respond to contact initiated by the Medicaid MCO Member of the public or Beneficiary. For example, if a Marketing representative is operating a booth at a health fair, the representative may give out information or materials, if requested. The representative may not approach a person and give out information or material (including promotional items).

SCDHHS reserves the right to attend all Marketing activities/events. The MCO must also secure the written permission of the business or event sponsor to conduct

Marketing/advertising activities (this satisfies the “written Prior Approval” requirement of the MCO Contract) and make this document available to SCDHHS, if requested. (Fax copies are acceptable.)

MCOs may conduct Marketing/advertising activities at events and locations including, but not limited to health fairs, health screenings, schools, churches, housing authority meetings, private businesses (excluding Providers referenced in this section), and other community events. The MCO may also be a participating or primary sponsor of a community event. The MCO may not present at employee benefit meetings.

Focus Groups and Member Surveys

With Prior Approval from SCDHHS, MCOs may perform general or focused Member surveys, and conduct focus group research in order to determine their Medicaid MCO Members’ expectations for improving services and benefits. The request to hold focus groups or conduct telephonic, social media type surveys must be received by SCDHHS by noon (12 PM EST) at least twenty (20) business days prior to the initial focus group meeting or survey being sent to Members.

The MCO must include the following information in the request for approval:

- Identity of the entity conducting the focus group event(s) or survey – MCO staff or contractor (including name of contractor)
- Date, time, contact information, and location of each event
- Selection criteria for participation
- Agenda/list of questions being asked to participants (The Division of Managed Care may require the MCO to include certain questions in the survey or focus group.)
- List all participant compensation in the form of cash, gift cards, or prizes, the value of which is not to exceed a total of \$25.00.

SCDHHS reserves the right to obtain additional information during the review and approval process and to attend focus group meetings.

The results and analysis of focus groups and surveys shall be submitted to the MCO’s program manager within forty-five (45) calendar days of the completion of the focus group project.

Marketing and educational materials should be uploaded to the MCO’s SharePoint site in the PR and Member Material Review library. All files submitted should have the following standard naming convention:

Document Labeling: Plan Code + Date of 1st submission + Type-Sequence #

Plan Code: ATC (Absolute Total Care), Advicare (AD), BC (BlueChoice Medicaid), Molina (MO), Select Health (FC), WellCare (WC)

Date: MMDDYYYY

Type: M=Member, P=provider, PR=Marketing Material

Appending Type: S=Spanish

Initial Member Material Submission:

Example: ATC-01182015-M-1

Example Definition: Absolute Total Care member material submission on 1/18/2015 initial submission.

Resubmissions:

Plan Code + Date of 1st submission + Type-Sequence #.Version #

Example: ATC-01182015-M-1.1

Example Definition: Absolute Total Care member material submission on 1/18/2015 1st resubmission.

Spanish Material:

Plan Code + Date of 1st submission + Type-Sequence # + Appending Type.Version#

Example: ATC-01182015-M-1-S.2

Example Definition: Absolute Total Care Spanish member material submission on 1/18/2015 1st resubmission.

13.0 Reporting Requirements

13.1 General Requirements

Section 13.1.1: The MCO must certify attest to the truthfulness, accuracy and completeness of Patient Centered Medical Home (PCMH) data, Capitated Rate Calculation Sheet (CRCS) data, Healthcare Effectiveness Data and Information Set (HEDIS) and encounters. The report companion guide has specific attestation sheets for these four reports. All attestations must be signed by the Chief Executive Officer (CEO), Chief Financial Officer (CFO), or by an individual who has delegated authority to sign for, and who, directly reports to the CEO and/or CFO. Attestations must be placed in the MCOs appropriate SharePoint library either monthly, quarterly or annually depending on the frequency of the reports occurrence.

In the event that the MCO needs to send a corrected report to SCDHHS. Those reports must be replaced on the MCO's SharePoint site. The MCO should replace the report in the correct SharePoint library with the following labeling on the report "reportname"-corrected MMDDYYYY. The MCO must email their program manager notifying them of the corrected report and the new report name and its location in the SharePoint library.

For all cites in Section 13.1.2 through 13.1.6, please refer to the contract for all requirements between MCO and SCDHHS.

Table 13.1

Should the due date for reporting fall on a weekend or state holiday, the report is due the prior business day (i.e., if the day to submit the report falls on a Saturday, the report is due the Friday prior or if that Friday is a state holiday, the report is due the previous day [Thursday]). Reports and associated definitions are housed in the MCO Reports Companion Guide. Current MCO contract requirement provisions indicate all quarterly reports due fifteen (15) days after the end of the quarter. SCDHHS will allow submission of quarterly reports up to thirty (30) days after the end of a quarter to allow for complete claim run out. As stated above in section 7, the FQHC/RHC wrap payment reports are due sixty (60) days after the end of the quarter.

For all cites in Section 13.1.7 through 13.1.10.5, please refer to the contract for all requirements between MCO and SCDHHS.

13.2 Reporting Requirements

For all cites in Section 13.2, please refer to the contract for all requirements between MCO and SCDHHS.

14.0 Encounter Data, Reporting and Submission Requirements

14.1 General Data Requirements

For all cites in Section 14.1 through Section 14.1.2.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.1.3 through Section 14.1.3.2: MCOs must submit a monthly attestation for all encounter data submitted in the month. Attestations of encounter data must be placed in the MCO's monthly SharePoint library. Please see the report companion guide for the specific attestation that must be submitted for encounter data monthly.

For all cites in Section 14.1.4 through Section 14.1.10.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.1.11: This biennial audit must be uploaded to the MCO's SharePoint "Required Submission's" library after completion of the security audit.

For all cites in Section 14.1.11.2 through Section 14.1.11.4.1, please refer to the contract for all requirements between MCO and SCDHHS.

14.2 Encounter Data

For all cites in Section 14.2.1 through Section 14.2.4, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.2.4.1: The MCO may submit encounters daily, daily encounter submissions may take place any day of the week, special instructions are included below for Friday, Saturday or Sunday submission. The limits to daily file submission are:

1. 5,000 record limit per file
2. 10 files are allowed each day (maximum submission for any single day Monday through Thursday is 50,000 records).
3. Friday, Saturday, and Sunday submissions are limited to a total of 50,000 records for the three day period.

SCDHHS batches all daily encounter submissions by the 29th of each month. Additional information regarding encounter specifications can be found in the MCO Report Companion Guide and the Encounter Companion guides found on the SCDHHS website.

For all cites in Section 14.2.4.2 through 14.2.14.6, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.2.15: Social Security Act Section 1903(m) (A) (ix) requires that managed care plans shall provide payment to Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) not less than the level and amount of payment which the plan would make for the services if the services were furnished by a Provider which is not a FQHC or RHC. The Social Security Act 1902 (bb) provides that the State shall provide a supplemental payment; if any, for the difference between the payment by the managed care plan and the fee-for-service rate that the FQHC or RHC would have received. The supplemental payments, herein referred to as the Wrap-Around payment methodology, are calculated and paid to ensure these entities receive reimbursement for services rendered to Medicaid MCO Members at least equal to the payment that would have been received under the traditional fee-for-service methodology. SCDHHS is the state agency responsible for ensuring the supplemental payment determinations (Wrap-Around methodology) are calculated at least every four (4) months. SCDHHS will provide these reconciliations to the entities on a quarterly basis.

The Medicaid MCO shall submit a report, quarterly, to its SharePoint quarterly library, all paid and denied encounter/claim data, by date of service, for all services rendered by FQHCs and RHCs for supplemental payment determination (Wrap-Around methodology) reconciliation purposes. Services eligible for Wrap-around methodology must meet fee-for-service coverage requirements. There shall be only one (1) encounter per day per recipient eligible for Wrap-around payment. The Contractor shall submit the name of each FQHC/RHC and detailed Medicaid encounter data paid to each FQHC/RHC. This information shall be submitted in the format required by the Department sixty (60) days after the end of the quarter to the SCDHHS. This is an exception to the normal quarterly report requirement of submission within fifteen (15) days of the end of a quarter.

Based on the FQHC/RHC's fiscal year end, an annual reconciliation of MCO payments and services to allowable reimbursement based on the FQHC/RHCs encounter rate will be determined. To complete this process, the following will be required:

Within one (1) year and sixty (60) days of the FQHC/RHC's quarterly report, all quarterly wrap-around files for the applicable quarter should be re-run (i.e. updated) in order to capture additional encounter and payment data not available or processed when the applicable quarter was originally run.

Transmission requirements remain the same as the interim quarterly submissions. That is, the updated files should be uploaded to the MCO's SharePoint quarterly library and the appropriate staff notified of it being uploaded to the site.

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 SCDHHS which may be found in the Reports Companion Guide. For your convenience an excel report template is available at <https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates>. If the submission is less than 97% accurate, the Department, at its discretion, may apply the liquid damages to the MCO as outlined in the MCO Contract with the Department (\$1,500 per day).

FQHC/RHC Wrap Data Files (Spreadsheets)

Encounter detail data and summary data shall be provided to SCDHHS as two (2) separate data spreadsheets in one Microsoft Excel workbook. A participation list shall be provided in a separate file. For your convenience an excel report template is available at <https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates>

14.3 Errors and Encounter Validation

Section 14.3.1.1: The MCO must submit encounters by the 25th of each month for batching purposes. Daily encounter submissions must take place Monday through Thursday of each week.

Section 14.3.1.2 through Section 14.3.4.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.3.5: SCDHHS has created companion guides for the 837I, 837P and NCPDP encounter transactions. These companion guides should be utilized along with the NPI/Taxonomy crosswalk table for the specific technical requirements of SCDHHS encounter submission. This information can be found at the agency's website at <https://msp.scdhhs.gov/managedcare>.

For all cites in Section 14.3.5.1 through Section 14.3.6.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.3.6.3.1: Encounter data submitted to SCDHHS in most instances must appear in the same manner that the original claim was submitted and paid/denied by the MCO. SCDHHS will only allow split encounters in the following instances:

1. 837I encounter: The original institutional claim has more than fifty (50) lines of data and/or billed and/or paid amounts on the claim exceed \$9,999,999.99.
2. 837P encounter: The original professional claim has more than eight (8) lines of data and/or billed and/or paid amounts on the claim exceed \$99,999.99 on any line of the claim.

In the event that the MCO must split the encounter the MCO must utilize an approach that does not materially alter the original claim submitted by the provider. For example, diagnosis codes on the encounter should remain in the same sequence as the original claim and claim billed/paid amounts on the split encounters should total the original billed/paid amount on the claim. Please refer to the 837 companion guides for further instructions regarding appropriate encounter submissions. Further deviations from this approach of data consistency between original claim and encounter will be formally communicated to the MCO in advance of the change through a report companion guide update, policy and procedure manual update and/or contract amendment.

Section 14.3.6.9 through Section 14.3.6.9.3: MCO performance is monitored, in part, through the review and analysis of reports that detail Encounter data, payment information, and services utilization. In order to: 1) provide an incentive for complete and accurate reporting and 2) reconcile Encounter submissions with MCO experience. MCOs are required to submit quarterly Capitation Rate Calculation Sheet (CRCS) reports to SCDHHS. This is to be done in a timely, complete and accurate manner. The data elements, and other requirements for the report format, can be found in the MCO Reports Companion Guide. CRCS reports are due within 105 days of the end of each calendar quarter. If there are delays in the MCO's receiving the previous quarter's CRCS analysis extensions of the time frame for CRCS submission are 30 days from the SCDHHS contractor's submission of the previous quarters CRCS results. The following reporting schedule is used:

- For the period January 1 to March 31, the CRCS report is due no later than July 14;
- For the period April 1 to June 30, the CRCS report is due no later than October 12;
- For the period July 1 to September 30, the CRCS report is due no later than January 12;
- For the period October 1 to December 31, the CRCS report is due no later than April 15 (or 16th in a leap year).

Should the due date specified above fall on a weekend or state holiday, the CRCS report is due the prior business day (i.e., if the day to submit the CRCS Report falls on a Saturday, the CRCS Report is due the Friday prior at noon [12 PM EST] or if that Friday is a state holiday, the CRCS Report is due the previous day [Thursday]). The CRCS report and associated definitions are housed in the MCO Reports Companion Guide.

MCO's must ensure the CRCS reports can be verified to a degree of at least 97% completeness for all claims (*i.e.*, an incompleteness rate means no more than 3% variance in utilization per 1,000 as outlined in the Milliman letter to the MCO.). SCDHHS will use the MCO's encounter data, or other method of data completion verification deemed reasonable by SCDHHS, to verify the completeness of the CRCS report in comparison to the MCO's encounter claims. SCDHHS reserves the right to change the method of data completion verification upon reasonable advance notice to the MCO.

The CRCS data reporting periods will be on a cumulative year-to-date basis instead of the previously utilized quarter by quarter methodology (*i.e.*, fourth (4th) quarter of calendar 2012 will be incurred claims and membership for the entire calendar year).

In the event the MCO's CRCS reports fails to meet the standards described above, SCDHHS will assess sanctions as described in the contract.

The following information explains the breakdown of the sliding scale penalty:

- Ninety-four percent (94%) or less completeness (utilization per 1,000) the full one quarter (0.25%) percent will be applied to the capitation payment paid to the MCO for each month of the reporting year.
- Ninety-four percent (94%) to 94.99999% of completeness (utilization per 1,000) SCDHHS will apply 0.125 of the capitation rate for each month of the reporting year.
- Ninety-five percent (95%) to 95.99999% of completeness (utilization per 1,000) SCDHHS will apply 0.0833 of the capitation rate for each month of the reporting year.
- Ninety-six percent (96%) to 96.99999% of completeness (utilization per 1,000) SCDHHS will apply 0.0625 of the capitation rate for each month of the reporting year. All penalties will be applied through a gross level adjustment no less than forty-five days after SCDHHS or its designee reports the year-to-date results.

CRCS reports must be uploaded to the MCO's SharePoint Quarterly library. Additionally the MCO must notify their SCDHHS assigned liaison that the information has been uploaded to the site.

14.4 System and Information Security Access Management Requirements

For all cites in Section 14.4, please refer to the contract for all requirements between MCO and SCDHHS.

15.0 Quality Assessment, Monitoring, and Reporting

15.1 Quality Assessment and Performance Improvement (QAPI)

For all cites in Section 15.1, please refer to the contract for all requirements between MCO and SCDHHS.

15.2 Performance Improvement Projects (PIP)

Section 15.2: The MCO is required to produce an annual written evaluation of the two (2) Performance Improvement Project(s) done each year these evaluations must be uploaded to the MCO's annual SharePoint library. These reports must also be shared with the MCO's network Providers and Medicaid MCO beneficiaries on an annual basis.

15.3 Member Satisfaction Survey

For all cites in Section 15.3.1 through Section 15.3.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 15.3.4: The MCO is required to produce annual member satisfaction surveys that must be uploaded to the MCO's annual SharePoint library. These reports must be uploaded in the following formats, Excel.

For all cites in Section 15.3.5 through Section 15.3.6, please refer to the contract for all requirements between MCO and SCDHHS.

15.4 Quality Performance Measures

For all cites in Section 15.4, please see Section 15.6 below for a complete explanation of Quality withhold program for calendar year 2014 and calendar year 2015.

15.5 Minimum Performance for Withhold Measures

For all cites in Section 15.5, please see Section 15.6 below for a complete explanation of Quality withhold program for calendar year 2014 and calendar year 2015.

15.6 Quality Withhold and Bonus Programs

Section 15.6.1: In July 2012, the Department began implementing a quality withhold program that required some component of the MCO's capitated payment be tied to performance on a set of clinical quality metrics.

SCDHHS has established at-risk performance-based quality objectives. These at-risk performance measures shall be measured each calendar year and will be based on nationally-recognized measurements of health plan quality, such as the Healthcare Effectiveness Data and Information Set (HEDIS). SCDHHS will use each plan's own

HEDIS metrics submitted to SCDHHS to evaluate performance for the purposes of the Withhold and Bonus Program.

SCDHHS has implemented an annualized withhold of 1.5%. The withhold will be applied retrospectively to the capitation rate payment for the first month after the end of the quarter and will be executed via gross level adjustment. The withhold amount debited each quarter will be calculated based on the total premiums paid during the previous quarter minus a 4% reduction for supplemental teaching payments. The withhold will remain at 1.5% through calendar year 2014, but SCDHHS may increase the withhold in subsequent years.

For measurement year 2013, MCOs are expected to score in at least the 25th percentile for each metric. Any MCO scoring below the 25th percentile in two (2) or more measures shall forfeit the entire annualized withhold amount.

MCOs are also expected to demonstrate improvement in each of the withhold measures. Any plan not demonstrating a one standard deviation improvement in any metric will forfeit the withhold amount for that metric. For the purpose of this policy, all metrics shall be weighted equally. For example, if an MCO fails to demonstrate a standard deviation improvement in 3 of 11 measures, the MCO will forfeit 3/11 of the overall withhold amount. Any metric with a score at or above the 75th percentile is exempt from the improvement requirement.

For the purposes of calculating the standard deviation used in determining whether or not a plan meets the incremental improvement standard (IIS) component of the Quality Withhold Program, SCDHHS utilizes the following formula:

$$\text{Standard Deviation} = \sqrt{\text{Rate} \times (1 - \text{Rate}) / \text{Denominator}}$$

For example:

CY2013 Numerator: 508 From Plan's HEDIS Report

CY2013 Denominator: 571 From Plan's HEDIS Report

CY2013 Rate: 89.0% [= 508/571]

Standard Deviation: 1.31% [=SQRT ((0.89*(1-0.89))/571)]

Any withhold amounts forfeited by an MCO will be used to create a bonus pool. Bonuses will be paid to managed care organizations for achieving at or above the 75th percentile in a withhold measure.

Beginning with measurement year 2014, the Quality Withhold and Bonus Program will be governed by the 2014 MCO contract. The specific MCO performance measures for 2013 and 2014 are shown in the following withhold metrics tables:

Withhold Metrics Measurement Year 2013				
	ATC	BC	SH	WC
Prevention and Screening				
Adolescent Well Care Visits — Mandatory	X	X	X	X
Breast Cancer Screening	X	X	X	X
Lead Screening in Children	X	X	X	X
Well Child 3rd, 4th, 5th, 6th Years of Life	X	X	X	X
Well Child Visits in First 15 Months	X	X	X	X
Chronic Disease and Behavioral Health				
Use of Appropriate Medication for People With Asthma (5 to 11years)	X	X	X	X
Use of Appropriate Medications for People with Asthma (19 to 50 years)	X		X	
Use of Appropriate Medications for People with Asthma (total)	X	X	X	X
Follow-Up Care After Hospitalization from Mental Illness — 30-Day Follow Up		X		X
Access and Availability				
Adult Access to Preventive/Ambulatory Services (20 to 44 years)	X	X	X	X
Adult Access to Preventive/Ambulatory Health Services (45 to 64 years)	X	X	X	X
Children's and Adolescent Access to PCP (7 to 11 years)	X	X	X	X
Children's and Adolescent Access to PCP (12 to 24 months)	X	X	X	X
Prenatal Care	X	X	X	X
Postpartum Care	X	X	X	X
Consumer Assessments of Health Plans Study (CAHPS)				
Customer Experience (Child)			X	
How Well Doctors Communicate (Adult)			X	
Getting Needed Care (Adult)		X		
Getting Needed Care (Child)		X		X
Rating of Personal Doctor (Child)	X			X
Rating of Health Plan (Child)	X			

Quality Withhold Requirements for New Plans

For new plans entering the SC Medicaid market, the following requirements will apply:

- Benchmark Year: The Benchmark Year is the first full calendar year for which the MCO is active in the SC Medicaid Market.
 - The Quality Withhold and Bonus Program, including liquidated damages for failure to meet the Minimum Performance Standard (MPS), shall not apply during the Benchmark Year.
- Transition Year: The Transitional Year is the second full calendar year for which the MCO is active in the SC Medicaid Market.
 - During the Transition Year, the MCO is required to achieve the VOC requirement described previously in this policy.
 - IIS Requirement During the Transitional Year: During the Transitional Year, the MCO is responsible for achieving the Incremental Improvement Standard (IIS), as defined in this policy. For measures that fail to achieve the IIS, the MCO shall forfeit the withhold amount for that measure. The IIS requirement will not apply for any measure for which the plan scores at or above the 75th percentile.
 - MSP Requirements During the Transitional Year:
 - *For Measures with Scores BELOW the 25th Percentile During the Benchmark Year*:
 - No liquidated damages will be imposed.
 - If the MCO achieves the MSP, the Withhold will be returned for the measure.
 - If the MCO fails to achieve the MSP, the MCO will forfeit 50 percent of the Withhold.
 - *For Measures with Scores ABOVE the 25th Percentile During the Benchmark Year*:
 - The standard Withhold Program policy shall apply, with liquidated damages and withhold forfeiture imposed if the measure falls below the 25th percentile during the Transition Year.

The standard Withhold and Bonus Program policy shall apply to the MCO beginning with its 3rd full year of operation.

Section 15.6.2 through Section 15.6.7: Beginning with calendar year 2015, the Quality Withhold and Bonus Program shall function as stipulated in Section 15 of the 2014 Contract and this policy document.

For calendar year 2015, SCDHHS will withhold an amount equal to 1.5% of the MCO's capitated payments. This amount may be increased in subsequent years. The withhold amount will be withheld from the MCO's capitated payments retrospectively on a quarterly basis.

Calculation of Withhold Amount

The following amounts will not be included in MCO capitation amounts for the purpose of calculating the withhold amount:

- Teaching supplements
- Gross level adjustments (that include payment for the Department's pass-through quality initiatives)
- Capitated rates paid for partial benefit members (such as members with family planning only benefits)

Withhold Measures

For the purposes of the Withhold and Bonus Program, the Department will evaluate the Withhold Measures listed in Attachment 1 of this policy. The Department will use the MCO's own Healthcare Effectiveness Data and Information Set (HEDIS) data submission for the purpose of identifying the quality metric.

Evaluation of Return of Withholds

To qualify for return of the Withhold, the MCO must meet the following requirements:

- Step 1: Value-Oriented Contracting. The MCO must meet the Value-Oriented Contracting (VOC) requirements in Section 15 of the 2014 Contract and Policy reflect below. If the MCO fails to meet the VOC threshold for the measurement (calendar) year, the MCO is disqualified from collecting any portion of the withhold.
- Step 2: Minimum Performance Standard. The MCO must meet the Minimum Performance Standard (MPS) for each of the Withhold Measures. For each measure for which the MCO fails to meet the MPS, the MCO will forfeit the measure-specific withhold amount. The withhold forfeiture shall be in addition to the liquidated damage for performance below the MPS, as stipulated in Section 15.4.17 of the 2014 MCO Contract.
 - The MPS is defined as the National HEDIS Medicaid 25th percentile.
 - The measure-specific withhold amount shall be equal to the total amount of the annual withhold divided by the number of withhold measures for the measurement year.

- Step 3: Incremental Improvement Standard. The MCO must meet the Incremental Improvement Standard (IIS) for each of the Withhold Measures. For each measure for which the MCO fails to meet the IIS, the MCO will forfeit the measure-specific withhold amount.
 - The IIS is defined as improvement, year-over-year, of one (1) standard deviation.
 - The measure-specific withhold amount shall be equal to the total amount of the annual withhold divided by the number of withhold measures for the measurement year.
 - Any metric Withhold Measure with a score at or above the 75th percentile is exempt from the IIS.

If an MCO fails to meet both the MPS and IIS for a single Withhold Measure, the measure-specific withhold amount will be forfeited only once.

Bonus Program

Withhold amounts forfeited by the MCOs will be used to create a bonus pool. Bonuses will be paid to MCOs for achieving at or above the 75th percentile in a withhold measure, in a manner determined by the Department.

Quality Report Requirements

The MCO must report to the Department, by July 1 of every year, the HEDIS and CAHPS data submissions, at both the summary and individual level. These submissions should include both final reports and raw data files.

Timing of Withhold Returns

The performance of the MCO will be evaluated upon receipt of the MCO's quality data. The Department will finalize its evaluation and return withhold amounts as soon as practical, but no later than October 31 following the measurement year.

Quality Withhold Requirements for New Plans

For new plans entering the SC Medicaid market, the following requirements will apply:

- Benchmark Year: The Benchmark Year is the first full calendar year for which the MCO is active in the SC Medicaid Market.
 - The Quality Withhold and Bonus Program, including liquidated damages for failure to meet the Minimum Performance Standard (MPS), shall not apply during the Benchmark Year.
- Transition Year: The Transitional Year is the second full calendar year for which the MCO is active in the SC Medicaid Market.

- o During the Transition Year, the MCO is required to achieve the VOC requirement described previously in this policy.
- o IIS Requirement During the Transitional Year: During the Transitional Year, the MCO is responsible for achieving the Incremental Improvement Standard (IIS), as defined in this policy. For measures that fail to achieve the IIS, the MCO shall forfeit the withhold amount for that measure. The IIS requirement will not apply for any measure for which the plan scores at or above the 75th percentile.
- o MSP Requirements During the Transitional Year:
 - *For Measures with Scores BELOW the 25th Percentile During the Benchmark Year*:
 - No liquidated damages will be imposed.
 - If the MCO achieves the MSP, the Withhold will be returned for the measure.
 - If the MCO fails to achieve the MSP, the MCO will forfeit 50 percent of the Withhold.
 - *For Measures with Scores ABOVE the 25th Percentile During the Benchmark Year*:
 - The standard Withhold Program policy shall apply, with liquidated damages and withhold forfeiture imposed if the measure falls below the 25th percentile during the Transition Year.

The standard Withhold and Bonus Program policy shall apply to the MCO beginning with its 3rd full year of operation.

NCQA HEDIS Reporting Measures

Pursuant to Section 15 of the 2014 Medicaid MCO Contract, MCOs are required to collect, report, and submit audited HEDIS measures for South Carolina Medicaid members. The MCO must include all measures specified in the Technical Specifications for Health Plans Volume 2 of the measurement year. SCDHHS may issue additional guidelines related to the inclusion of retired measures for any reporting period.

Audit Requirements

Each MCO must contract with an NCQA-licensed organization (LO) and undergo a HEDIS Compliance Audit conducted by an NCQA-Certified HEDIS Compliance Auditor (CHCA). A listing of LOs and CHCAs can be found at the NCQA website: <http://www.ncqa.org/tabid/204/Default.aspx>.

All audits must be conducted according to NCQA's *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*.

Audit Scope: The audit scope must include, at a minimum, all SCDHHS required measures for the South Carolina Medicaid population.

Audit Timeline: Audits must be completed in accordance with NCQA's timeline.

Audit Components: All audits must include: (1) auditor review of Record of Administration, Data Management and Processes (Roadmap) completed by the MCO, (2) source code/software certification review, (3) supplemental data validation [if applicable], (4) medical record review validation, (5) onsite visit, and (6) final rate review.

Final Audit Report: The Final Audit Report (FAR), prepared by the audit organization, must address:

- Information about the LO
- Audit team information
- MCO information
- Audit scope, product lines, timeline
- Supplemental database findings
- Source code review findings
- MRR validation findings
- Information System (IS) standards findings
- Final audit results statement

Data Submission Protocol

1. Audited HEDIS Data

MCOs are required to submit their **audited HEDIS data** to SCDHHS as follows:

Submission Tool: NCQA's Interactive Data Submission System (IDSS)—must be the final, auditor-locked version

Submission Format: Data-Filled Workbook (Excel) and CSV Workbook for each submission

Submission Units: Overall South Carolina Medicaid population

Naming Conventions: Maintain the IDSS-generated naming convention for each file (e.g., workbook-four digit submission ID.xls or csv.)

Example: “workbook-1234.xls” or “workbook-1234.csv”

Submission Method: Upload files to the MCO’s designated SCDHHS SharePoint site.

Submission Due: July 1 of each year

2. MCOs are required to submit the **Final Audit Report (FAR)** to SCDHHS as follows:

Submission Format: Final Word or PDF file prepared by audit organization

Submission Method: Upload files to the MCO’s designated SCDHHS SharePoint site.

Submission Due Date: July 1 of each contract year

A review of each FAR will be conducted in order to determine if any data collection or reporting issues were identified. In addition, any measure that is assigned an audit result of “Not Report” (i.e., NR) will be evaluated to determine the issue(s) that resulted in the assignment of an NR. MCOs must be prepared to provide any requested back-up documentation to account for an NR audit designation. Based on the findings from the review of the FARs and any NR audit result assigned, SCDHHS will have the discretion to require a corrective action plan or other action as designated by the SCDHHS.

Data Certification Requirements

Each MCO must submit the signed data certification letter attesting to the accuracy and completeness of: (1) the audited HEDIS data and (2) the Final Audit Report (FAR). The certification template is attached and also available in the Policy and Procedure Manual.

The MCO must enter the file names for each IDSS file submitted. The data certification letter should be submitted to MCO’s contract administrator via email.

Data certification letters are due on the same day that the data files are submitted.

Data Submission Timeline

MCOs are required to adhere to the following timeline for the submission of self-reported HEDIS data:

SUBMISSION REQUIREMENT	DUE DATE
Final, locked IDSS Report	July 1
Final Audit Report (FAR)	July 1
Certification Letter	July 1

CAHPS Data Submission Requirements

Section 1: CAHPS Survey Administration Requirements

Each MCO must contract with an NCQA-Certified HEDIS Survey Vendor to administer HEDIS CAHPS surveys to the MCO's South Carolina Medicaid Members.

- The HEDIS CAHPS surveys must be administered in accordance with NCQA's *HEDIS Volume 3: Specifications for Survey Measures* for each of the contract years.
- The HEDIS CAHPS surveys must be administered for both adult and child members using the NCQA HEDIS CAHPS 5.0H Adult Medicaid Health Plan Survey and the NCQA HEDIS CAHPS 5.0H Child Medicaid Health Plan Survey (with the chronic conditions measurement set), respectively.
- The MCO's designated survey vendor must indicate to NCQA that the MCO wants to publicly report its data.

Section 2: CAHPS Data Submission Requirements

MCOs are required to submit the following items to SCDHHS by July 1, in accordance with the Section 15 of the MCO Contract:

- NCQA Summary-Level Reports
- CAHPS Survey Data Files:
 - NCQA Member-Level Data Files
 - State-Specific Member-Level Data Files
- MCO-Specific Survey Instruments
- Survey Vendor Contact Information

MCOs must upload the required files to their MCO-specific SCDHHS SharePoint site.

NCQA Summary-Level Reports

Description: NCQA produces reports containing summary-level survey results for each organization that submits data to NCQA. Individual reports are provided for each data submission (e.g., child Medicaid data, adult Medicaid data). These reports contain information on survey attributes (e.g., sample size, response rate) in addition to

summary-level results (e.g., three-point means, top box scores) for the global ratings and composite measures.

Data Source: These files are downloaded from NCQA’s Interactive Data Submission System (IDSS), following submission of the MCO’s CAHPS survey data to NCQA via the IDSS.

Requirement: The files listed in Table 1 below must be submitted to SCDHHS in the prescribed formats and using the naming conventions specified in the table.

Table 1. NCQA Summary Level Report Files

FILE DESCRIPTION	FORMAT	NAMING CONVENTION FOR DATA FILE SUBMISSION
MCO’s Adult Medicaid NCQA HEDIS CAHPS Survey Results Report	PDF	DAM[MCO Provider ID]_sr.pdf
MCO’s Medicaid Child with CCC – CCC Population – NCQA HEDIS CAHPS Survey Results Report	PDF	DCC[MCO Provider ID]_ccc_sr.pdf
MCO’s Medicaid Child with CCC – General Population – NCQA HEDIS CAHPS Survey Results Report	PDF	DCC[MCO Provider ID]_gp_sr.pdf

NCQA Member-Level Data Files

Description: NCQA Member-Level Data Files are prepared by the MCO’s designated survey vendor in accordance with the *HEDIS CAHPS Survey Validated Member-Level Data File Layouts*. Each NCQA member-level data file contains information about the health plan, the survey submission, the blinded sample, and the response data for each sampled member.

Data Source: These data files are downloaded from NCQA’s IDSS, following submission of the MCO’s CAHPS survey data to NCQA via the IDSS.

Requirement: The files listed in Table 2 below must be submitted to SCDHHS in the prescribed formats and using the naming conventions specified in the table.

Table 2. NCQA Member-Level Data Files

FILE DESCRIPTION	FORMAT	NAMING CONVENTION FOR DATA FILE SUBMISSION
MCO’s Adult Medicaid NCQA HEDIS CAHPS member-level data file	TXT	DAM[MCO Provider ID].txt
MCO’s Child Medicaid NCQA HEDIS CAHPS member-level data file	TXT	DCCM[MCO Provider ID].txt

State-Specific Member-Level Data Files

Description: State-specific member-level data files are prepared by the MCO’s designated survey vendor in accordance with the requirements established below:

- The state-specific member-level data files contain the same data as the NCQA member-level data files, but also contain additional data not submitted to NCQA.
- The state-specific member-level data files contain member-level response data for any supplemental items added to the surveys by SCDHHS. These files also contain member-level data for specific demographic variables requested by SCDHHS.

Data Source: These data files are prepared by the MCO’s designated survey vendor using the MCO’s CAHPS survey data and sample frame file information.

Requirement: The files listed in Table 3 below must be submitted to SCDHHS in the prescribed formats and using the naming conventions specified in the table.

Table 3. State-Specific Member-Level Data Files

FILE DESCRIPTION	FORMAT	NAMING CONVENTION FOR DATA FILE SUBMISSION
MCO’s Adult Medicaid CAHPS state-specific member-level data file	TXT	DAM[MCP Provider ID]_SC Specific.txt
MCO’s Child Medicaid CAHPS state-specific member-level data file	TXT	DCCM[MCP Provider ID]_SC Specific.txt

MCO-Specific Survey Instruments

Description: The final, vendor formatted surveys approved by NCQA and used to administer the HEDIS CAHPS survey to the MCO’s SC Medicaid members.

Requirement: The files listed in Table 4 below must be submitted to SCDHHS in the prescribed formats and using the naming conventions specified in the table.

Table 4. MCP-Specific Survey Instrument Files

FILE DESCRIPTION	FORMAT	NAMING CONVENTION FOR DATA FILE SUBMISSION
MCO’s CAHPS Adult Medicaid Health Plan Survey Instrument	PDF	Adult_CAHPS_Survey.Year.[MCO Provider ID].pdf
MCO’s CAHPS Child Medicaid Health Plan Survey Instrument (with the chronic conditions measurement set)	PDF	Child_CAHPS_Survey.Year.[MCO Provider ID].pdf

Survey Vendor Contact Information

Description: This file contains the following information for the NCQA-Certified HEDIS Survey Vendor that administered the MCO's CAHPS survey: vendor name, vendor address, name of vendor contact (for technical questions regarding data submissions), telephone number for vendor contact, and email address for vendor contact.

Requirement: The survey vendor contact information described above must be submitted to the SCDHHS SharePoint site in PDF format using the following naming convention: Survey_Vendor_Contact_Info.Year.[MCO Provider ID].pdf

CAHPS Data Collection and Submission Certification Requirements

Each MCO must submit the signed data certification letter attesting to the accuracy and completeness of the CAHPS data submission.

The MCO must enter the file names for each file submitted. The data certification letter should be submitted to MCO's contract administrator via email.

Data certification letters are due on the same day that the data files are submitted.

Disposition of Undistributed Withhold Funds

The goal is to return all the withhold funds to the MCOs. In the event the withhold pool is not fully distributed to the MCOs, the Department, at its discretion, may either maintain the funds or may distribute in support of other health plan quality initiatives.

2014 & 2015 Withhold Measures

Diabetes Optimal Care (CDC)

- Eye Exam (Retinal) Performed
- Hemoglobin A1c (HbA1c) Testing
- Medical Attention for Nephropathy

Asthma Optimal Care

- Medication Management for People with Asthma (MMA), *Total - Medication Compliance 50%*
- Use of Appropriate Medication for People with Asthma (ASM), *Total*

Preventive Health Optimal Care

- Well-Child Visits in the First 15 Months of Life (w15), *6+ Visits*
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)
- Adolescent Well-Care Visits (AWC)

- Adults' Access to Preventive/Ambulatory Health Services (AAP), *Total*
- Timeliness of Prenatal Care (PPC)

Behavioral Health

- Follow-Up Care for Children Prescribed ADHD Medication (ADD), *Continuation and Maintenance (C&M) Phase*

15.7 Value Oriented Contracting (VOC)

For all cites in Section 15.7.1 through Section 15.7.3.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 15.7.4 through Section 15.7.4.2: To improve the quality of care provided to Medicaid members and to enhance the value of the dollars spent in the Medicaid program, MCOs are expected to pursue quality-based, non-fee-for-service contracts with their Provider networks. In supporting the Department's goal of achieving 20% value-oriented payments by 2018, MCOs must meet the following VOC targets:

VOC Targets by 2018	
Year	Target
2015 (January 1, 2015 through December 31, 2015)	5% of Payments
2016 (January 1, 2016 through December 31, 2016)	12% of Payments
2017 (January 1, 2017 through December 31, 2017)	20% of Payments

For the purposes of this policy, a value-oriented contract shall be any agreement with a network Provider for which some component of payment is linked to Provider performance. MCOs are encouraged to pursue innovation in the pursuit of negotiating value-oriented contracts, so long as the contracts meet the following characteristics:

- At least some component of the Provider's reimbursement shall be issued differentially according to the Provider's performance.
- There must be some measure of the quality of care (such as outcomes metrics, adherence to guidelines, etc.). Sub-capitated or bundled payment arrangements that do not incorporate some measure of quality or value shall not be counted as value-oriented contracts.
- VOC contracts cannot be an existing unmodified managed care contractual function.

MCOs are encouraged to engage with organizations that are active in developing innovative payment reform strategies, such as Catalyst for Payment Reform (CPR).

Annually, no later than March 31, each MCO shall submit to the Department a certification of the percentage of payments made pursuant to a value-oriented contract. The VOC percent shall be calculated by dividing the total dollars issued pursuant to a VOC by the total dollars spent by the MCO on healthcare services, excluding payments made for durable medical equipment or through the pharmacy benefit.

$$VOC\% = \frac{\text{Dollars Spent Pursuant to VCO}}{\text{Total Dollars on Healthcare Services, except Pharmacy \& DME}}$$

The VOC calculation should include all claims with a date of service during the measurement period (January 1 through December 31) that are received by the MCO by March 1.

For arrangements where some portion of the Provider's payment meets the requirements of VOC, the entire payment to the Provider may be counted as VOC. For example, if a Provider contract provides for fee-for-service payment with a quality-based PMPM payment, both the claims payments and PMPM shall be counted as VOC payments.

For payments made to Providers as a pass-through from SCDHHS, such as the current PCMH arrangement, 50% of the value of the payments shall be counted toward the MCO's VOC requirement.

The Department reserves the right to audit any contract claimed to qualify as VOC as well as any payments claimed to have been made pursuant to a VOC contract. The determination for whether or not a Provider contract qualify as a VOC shall rest solely with the Department.

Beginning August 1, 2014, MCOs **may** submit a contract or draft contract to the Department for determination of whether or not it qualifies as VOC. The Department will review the contract and return a determination in writing within 30 days of receipt of the request. Such requests should be forwarded to the MCO's SCDHHS account contact.

The MCO shall use the document attached as Attachment 1 for its annual certification.

Policy XXX

Attachment 1

Value Oriented Contracting (VOC) Certification

MCO Name: _____

Measurement Period: _____

Service Type	Total Expenditures	Expenditures Pursant to VOC	% VOC
Inpatient Hospital			--
Outpatient Hospital			--
Physicians			--
Other Medical Professionals			--
Miscellaneous/Other			--
SCDHHS Pass-Through Payments			--

Pass-Through VOC Payments	
---------------------------	--

Total VOC %	--
--------------------	-----------

Signature _____ Title _____

Print Name _____ Date _____

Instructions:

Input data into the green cells, as indicated in the chart.
 Data elements in red cells will calcualte automatically.
 The measurement period should be a full calendar year.
 This certification is due by March 31 following the measurement year.
 The certification should be submitted to the MCO's SCDHHS account contact.

15.8 NCQA Accreditation

For all cites in Section 15.8, please refer to the contract for all requirements between MCO and SCDHHS.

15.9 External Quality Review (EQR)

Section 15.9.1 through Section 15.9.5: The MCO will assist SCDHHS and SCDHHS's External Quality Review Organization (EQRO) in the identification of Provider and beneficiary data required to carry out the annual review.

- A. The MCO will arrange orientation meetings for physician office staff concerning on-site medical chart reviews.
- B. The MCO will assist the SCDHHS and the EQRO under contract with the SCDHHS, as needed, in securing records needed to conduct off-site medical chart reviews.
- C. MCO will facilitate training to its Providers.
- D. Whether announced or unannounced, the MCO shall allow duly authorized agents, or representatives of the State or Federal government, access to MCO's premises or MCO Subcontractor's premises to inspect, audit, monitor or otherwise evaluate the performance of the MCO's or Subcontractor's contractual activities.

The annual review performed by the EQRO may include but not be limited to the following areas of MCO operation:

Assure that all persons, whether they are employees, agents, Subcontractors, or anyone acting for, or on behalf of, the MCO and/or Provider, are properly licensed and/or certified under applicable state law and/or regulations, and are eligible to participate in the Medicaid/Medicare program. Audits and reviews may also review subcontractor requirements for checking the Excluded Parties List. Reviews may include ensuring any MCO employees or subcontractor is not 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 significant to the Subcontractor's contractual obligation. The Subcontractor 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.

- A. Ensuring the MCO maintains a copy of all plan Providers current valid licenses to practice, or be able to access a copy within seventy-two (72) hours, if requested.
- B. Ensuring the MCO has policies and procedures for approval of new Subcontractors and termination or suspension of a Subcontractor.
- C. Ensuring the MCO has a mechanism for reporting Quality deficiencies which result in suspension or termination of a Subcontractor.
- D. Ensuring there are written policies and procedures for assigning every Medicaid MCO Member a Primary Care Provider.

- E. Ensuring the MCO maintains the management and integration of healthcare through Primary Care Providers. The MCO must provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, professional, allied, and paramedical personnel for the provision of Covered Services, including all Emergency Services, on a 24-hour-a-day, 7-day-a-week basis.
- F. Ensuring the MCO has a referral system for Medically Necessary, specialty, secondary and tertiary care.
- G. Reviewing the assurance of the provision of emergency care, including an education process to help assure that Medicaid MCO Members know where and how to obtain medically necessary care in emergency situations.
- H. Ensuring the MCO has specific referral requirements for in and out of plan services. MCOs shall clearly specify referral requirements to Providers and Subcontractors and keep copies of referrals (approved and denied) in a central file or in the Medicaid MCO Member's medical record.
- I. That the MCO has a qualified representative to interface with the case manager for those Medicaid MCO Members receiving out of plan Continuity of Care and case management services. The MCO representative shall work with the case manager to identify what Medicaid Covered Services, in conjunction with the other identified social services, are to be provided to the Medicaid MCO Member.
- J. Ensuring that all MCO beneficiary medical records are accurate, legible and safeguarded against loss, destruction, or unauthorized use and are maintained in an organized fashion for all individuals evaluated or treated, accessible for review and audit. Also, the MCO shall maintain, or require its network Providers and Subcontractors to maintain, individual Medical Records for each Medicaid MCO Member. Such records shall be readily available to the SCDHHS and/or its designee and contain all information necessary for the medical management of each enrolled Medicaid MCO Member. Procedures shall also exist to facilitate the prompt transfer of patient care records to other in- or out-of-plan Providers.
- K. Ensuring medical records are readily available for MCO-wide QA and UM activities and provide adequate medical and clinical data required for QA/UM.
- L. Ensuring the MCO has adequate information and record transfer procedures to provide Continuity of Care when Medicaid MCO beneficiaries are treated by more than one Provider.
- M. All medical records, at a minimum, must contain the following items:
 - Patient name, Medicaid identification number, age, sex, and places of residence and employment and responsible party (parent or guardian)
 - Services provided through the MCO, date of service, service site, and name of service Provider
 - Medical history, diagnoses, prescribed treatment and/or therapy, and drug(s) administered or dispensed. The Medical Record shall commence on the date of the first patient examination made through, or by the MCO.

- Referrals and results of specialist referrals
 - Documentation of emergency and/or after-hours encounters and follow-up
 - Signed and dated consent forms
 - For pediatric records (under 19 years of age) record of immunization status. Documentation of advance directives, if completed.
 - The documentation for each visit must include:
 - Date
 - Purpose of visit
 - Diagnosis or medical impression
 - Objective finding
 - Assessment of patient's findings
 - Plan of treatment, diagnostic tests, therapies and other prescribed regimens
 - Medications prescribed
 - Health education provided
 - Signature and title or initials of the Provider rendering the service. If more than one person documents in the Medical Record, there must be a record on file as to what signature is represented by which initials.
- N. Ensure the MCO has written utilization management protocols for 1) denial of services, 2) prior approval, 3) hospital discharge planning and 4) retrospective review of claims
- O. A Processes to identify utilization problems and undertake corrective action
- P. An emergency room log, or equivalent method, specifically to track emergency room utilization and Prior Authorization (to include denials)
- Q. Processes to assure abortions comply with 42 CFR 441 subpart E-Abortions, and hysterectomies and sterilizations comply with 42 CFR 441 subpart F-Sterilizations.
- R. Ensure that all Medicaid MCO beneficiaries are provided with approved written information regarding the nature and extent of their rights and responsibilities as a Medicaid MCO beneficiary. The minimum information shall include:
- A description of the managed care plan
 - A current listing of practitioners providing health care
 - Information about benefits and how to obtain them
 - Information on the confidentiality of patient information
 - Grievance and appeal rights

- Advance directive information as described in 42 CFR 417.436 and 489 subpart
 - Eligibility and enrollment information
- S. Ensure that the MCO has written Policies and procedures for grievance and appeals that are distributed to Medicaid MCO Members. These Policies and procedures must comply with the provisions of the MCO Contract.
- T. That the grievance and appeal literature informs Medicaid MCO Members they must exhaust the MCO's Appeal process prior to filing for a state fair hearing, and informs the Medicaid MCO members of the state fair hearing process and its procedures. The policies must ensure the MCO:
- Attempts to resolve grievances through internal mechanisms whenever possible and to contact the member by letter or telephone providing them with the MCO's resolution.
 - Maintains a separate spreadsheet for oral and written Grievances and Appeals and records of disposition

Section 15.9.5.1 through 15.9.7: SCDHHS staff approves all of the MCO's Corrective Action Plan (CAP) and monitoring of disposition of identified items developed as a result of the annual external QA evaluation or any discrepancies found by the SCDHHS that require corrective actions. When deficiencies are found, the MCO will submit a Plan of Correction which includes the following:

- Identifies each deficiency
- Specifies the corrective action to be taken
- Provides a timeline by which corrective action will be completed

All Corrective Action Plan quarterly updates must be submitted to the MCO's SharePoint Required Submissions site and the MCO's program representative must be notified of the addition to the site. All Corrective Action Plans and their updates must include an attestation to completeness and accuracy and be signed by the MCO's CEO.

15.10 Provider Preventable Conditions

For all cites in Section 15.10.1 through Section 15.10.3.1, please refer to the contract for all requirements between MCO and SCDHHS.

For all cites in Section 15.10.4 through Section 15.10.5: The MCO must ensure that the following Other Provider Preventable Conditions (OPPCs) are added to its non-payment policy for Provider preventable conditions (PPCs).

- Postoperative death in normal healthy patient
- Death/disability associated with use of contaminated drugs, devices or biologics

- Death/disability associated with use of device other than intended
- Death/disability associated to medication error
- Maternal death/disability with low-risk delivery
- Death/disability associated with hypoglycemia
- Death/disability associated with hyperbilirubinemia in neonates
- Death/disability due to wrong oxygen or gas

16.0 Department's Responsibilities

16.1 Department Contract Management

For all cites in Section 16.1, please refer to the contract for all requirements between MCO and SCDHHS.

16.2 Payment of Capitated Rate

For all cites in Section 16.2, please refer to the contract for all requirements between MCO and SCDHHS.

16.3 Notification of Medicaid MCO Program Policies and Procedures

For all cites in Section 16.3, please refer to the contract for all requirements between MCO and SCDHHS.

16.4 Quality Assessment and Monitoring Activities

For all cites in Section 16.4, please refer to the contract for all requirements between MCO and SCDHHS.

16.5 Fee-for-Service (FFS) Reporting to MCOs

Section 16.5.1: The Department has a secure File Transfer Protocol (FTP) site for each MCO. The Department will load FFS claims to the MCO's FTP site for all beneficiaries enrolled with the MCO each month.

16.6 Request for Plan of Correction

For all cites in Section 16.6, please refer to the contract for all requirements between MCO and SCDHHS.

16.7 External Quality Review

Section 16.7.1: Annually, each MCO must undergo a quality audit with the Department's contracted External Quality Review Organization (EQRO). The quality review includes a

desk review of the various Policies and Procedures, committee minutes, etc., as well as interviews with key staff members. The MCO will be expected to have a number of materials available during the EQRO review. The review is completed to ensure that the MCO continues to be in compliance with the Department's contract and all applicable federal requirements.

If deficiencies are noted during the review, the MCO will be required to submit a Plan of Correction (PoC) to SCDHHS. Time frames given for correcting deficiencies will be based on the severity and scope of the deficiencies.

The MCO is scored against a set of nationally recognized standards that represent SCDHHS' expectations for successful operation within the South Carolina Medicaid Program. SCDHHS will supply a copy of the most current version of the quality standards upon request. The review is conducted at the MCO's South Carolina location. The External Quality Review Organization (EQRO) will coordinate with the MCO to schedule the Review and to communicate the EQRO's expectations.

16.8 Marketing

For all cites in Section 16.8, please refer to the contract for all requirements between MCO and SCDHHS.

16.9 Grievances/Appeals

For all cites in Section 16.9, please refer to the contract for all requirements between MCO and SCDHHS.

16.10 Training

For all cites in Section 16.10, please refer to the contract for all requirements between MCO and SCDHHS.

17.0 Termination and Amendments

17.1 Termination

For all cites in Section 17.1, please refer to the contract for all requirements between MCO and SCDHHS.

17.2 Termination under Mutual Agreement

For all cites in Section 17.2, please refer to the contract for all requirements between MCO and SCDHHS.

17.3 Termination by Department for Breach

For all cites in Section 17.3, please refer to the contract for all requirements between MCO and SCDHHS.

17.4 Termination for Unavailability of Funds

For all cites in Section 17.4, please refer to the contract for all requirements between MCO and SCDHHS.

17.5 Termination for CONTRACTOR Insolvency, Bankruptcy, Instability of Funds

For all cites in Section 17.5, please refer to the contract for all requirements between MCO and SCDHHS.

17.6 Termination by the CONTRACTOR

For all cites in Section 17.6, please refer to the contract for all requirements between MCO and SCDHHS.

17.7 Termination for Loss of Licensure or Certification

For all cites in Section 17.7, please refer to the contract for all requirements between MCO and SCDHHS.

17.8 Termination for Noncompliance with the Drug Free Workplace Act

For all cites in Section 17.8, please refer to the contract for all requirements between MCO and SCDHHS.

17.9 Termination for Actions of Owners/Managers

For all cites in Section 17.9, please refer to the contract for all requirements between MCO and SCDHHS.

17.10 Non-Renewal

For all cites in Section 17.10, please refer to the contract for all requirements between MCO and SCDHHS.

17.11 Termination Process

For all cites in Section 17.11, please refer to the contract for all requirements between MCO and SCDHHS.

17.12 Amendments and Rate Adjustments

For all cites in Section 17.12, please refer to the contract for all requirements between MCO and SCDHHS.

18.0 Audits, Fines and Liquidated Damages

18.1 Audit

For all cites in Section 18.1 through Section 18.1.3: Audits referenced in these contract sections are in addition to the annual audit done by EQRO.

For all cites in Section 18.1.4, please refer to the contract for all requirements between MCO and SCDHHS.

18.2 Liquidated Damages for Failure to Meet Contract Requirements

For all cites in Section 18.2, please refer to the contract for all requirements between MCO and SCDHHS.

18.3 Corrective Action Plan

For all cites in Section 18.3, please refer to the contract for all requirements between MCO and SCDHHS.

18.4 Sanctions

For all cites in Section 18.4.1 through Section 18.4.1.15, please refer to the contract for all requirements between MCO and SCDHHS.

Section 18.4.1.16: Rules Regarding Physician Incentive Plans (PIP) in Prepaid Health Organizations

The PIP rules apply to Medicaid prepaid organizations subject to section 1903(m) of the Social Security Act, *i.e.*, requirements for federal financial participation in contract costs, including both federally qualified MCOs and State Plan defined MCOs.

The MCO may operate a PIP under the following circumstances: (1) no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual enrollee; and (2) the stop-loss protection, enrollee survey, and disclosure requirements of this section are met.

The MCO must maintain adequate information specified in the PIP regulations and make available to the SCDHHS, if requested, in order that the SCDHHS may adequately monitor the MCO's PIP if applicable. The disclosure must contain the following information in detail sufficient to enable the SCDHHS to determine whether the incentive plan complies with the PIP requirements:

1. Whether services not furnished by the physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.

2. The type of Incentive Arrangement; for example, withhold, bonus, capitation
3. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus
4. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection
5. The panel size and, if patients are pooled, the approved method used
6. In the case of capitated physicians or physician groups, Capitation Payments paid to primary care physicians for the most recent calendar year broken down by percent for Primary Care Services, referral services to specialists, and hospital and other types of Provider (for example, nursing home and home health agency) services
7. In the case of those prepaid plans that are required to conduct Beneficiary surveys, the survey results (which must be provided in a timely manner to Medicaid Recipients upon request)

The disclosure requirements numbers 1 through 5 must be provided prior to contract approval and upon the effective date of its contract renewal. Disclosure requirement number 6 must be provided for the previous calendar year by April 1 of each year. The MCO must disclose this information to the SCDHHS when requested. The MCO must provide the capitation data required no later than three months after the end of the calendar year. The MCO will provide to the Beneficiary upon request whether the prepaid plan uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement, whether stop-loss protection is provided, and the survey results of any enrollee or disenrollee surveys conducted.

Disclosure Requirements Related to Subcontracting Arrangements

A MCO that contracts with a physician group that places the individual physician members at substantial financial risk for services they do not furnish must do the following:

- Disclose to the SCDHHS, upon request, any incentive plan between the physician group and its individual physicians that bases compensation to the physician on the use or cost of services furnished to Medicaid Beneficiaries. The disclosure must include the required information and be made at the times specified.
- Provide adequate stop-loss protection to the individual physicians.
- Conduct enrollee surveys

A MCO that contracts with an intermediate entity (e.g., an individual practice association, or physician hospital organization) and which bases compensation to its contracting physicians or physician groups on the use or cost of referral services furnished to Medicaid Beneficiaries must comply with requirements above.

Recipient Survey

Federal regulations 42 CFR 417.479(g) (1) requires that organizations that operate incentive plans that place physicians or physician groups at substantial financial risk (SFR) must conduct surveys of enrollees. Surveys must include either all current Medicaid enrollees in the MCO's plan and those that have disenrolled other than because of loss of eligibility or relocation, or choose to conduct a valid statistical sample.

According to 42 CFR 417.479(g)(iv), enrollee surveys must be conducted no later than one year after the effective date of the contract and at least annually thereafter. As long as physicians or physician groups are placed SFR for referral services, surveys must be conducted annually. The survey must address enrollees and disenrollees satisfaction with the quality of services, and their degree of access to the services. Medicare contracting MCOs will meet the survey requirement via a CMS sponsored survey conducted by the Agency for Health Care Policy and Research through their Consumer Assessments of Health Plans Study (CAHPS) process. SCDHHS has the authority to utilize the Medicaid version of CAHPS to meet the survey requirement. MCOs, upon completion of approved survey tool, will be expected to compile, analyze and summarize survey data within 120 days and submit the results to the SCDHHS.

Note: If Disenrollment information is obtained at the time of Disenrollment from all Beneficiaries, or a survey instrument is administered to a sample of disenrollees, your current method will meet the disenrollee survey requirements for the contract year.

A. Withholding of Federal Financial Participation (FFP)

Section 1903(m) of the Act specifies requirements that must be met for states to receive Federal Financial Participation (FFP) for contracts with MCOs. Federal regulation 42 CFR 434.70(a) (2002, as amended, sets the conditions for FFP. Federal funds will be available to Medicaid for payments to MCOs only for the periods that the MCOs comply with the PIP requirements in 42 CFR 417.479(d)-(g), (h)(1), (h)(3), and 417.479(l) requirements related to Subcontractors. These regulations cover: 1) the prohibition of physician payments as an inducement to reduce or limit covered Medically Necessary Services furnished to an individual enrollee, 2) proper computation of substantial financial risk, 3) physician stop-loss protection, 4) enrollee survey requirements, and 5) disclosure requirements.

Federal regulations 42 CFR 434.70(b) provides that CMS may withhold FFP for any period during which the State fails to meet the State plan requirements of this part.

B. Intermediate Sanctions and/or Civil Money Penalties

Federal Regulations 42 CFR 438.700(a) states that intermediate sanctions (42 CFR 438.702, types of intermediate sanctions) may be imposed on a MCO with a risk comprehensive contract which fails to comply with any of the requirements of 417.479(d)-(g), or fails to submit to SCDHHS its physician incentive plans as required or requested in 42 CFR 422.208 and 422.210.

In accordance with 42 CFR 1003.103(f)(1)(vi), the OIG may impose a Civil Monetary Penalty of up to \$25,000 for each determination by CMS that a contracting organization has failed to comply with 417.479(d)-(g) and 434.70. Civil Monetary Penalties may be imposed on the organization in addition to, or in place of the imposed sanctions.

Definitions for Physician Incentive Plan Requirements

Physicians Incentive Plan – Any compensation arrangement between a MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid Beneficiaries enrolled in the MCO

Physician Group – A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Intermediate Entity – Entities which contract between an MCO or one of its Subcontractors and a physician or physician group. An Individual Practice Association (IPA) is considered an intermediate entity if it contracts with one or more physician groups in addition to contracting with individual physicians.

Substantial Financial Risk – An incentive arrangement based on referral services that place the physician or physician group at risk for amounts beyond the risk threshold. The risk threshold is 25 percent.

Bonus – A payment that a physician or entity receives beyond any salary, fee-for-service payment, capitation, or returned withhold. Quality bonuses and other compensation that are not based on referral levels (such as bonuses based solely on care, patient satisfaction or physician participation on a committee) are not considered in the calculation of substantial financial risk, but may be revisited at a later date.

Capitation – A set dollar payment per patient per unit of time (usually per month) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

Payments – The amount a MCO pays physicians or physician group for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician group to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of this subpart.

Referral Services – Any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish.

Risk Threshold – The maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. The risk threshold is 25 percent.

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.

For all cites in Section 18.4.1.17 through Section 18.4.2, please refer to the contract for all requirements between MCO and SCDHHS.

18.5 Plan of Correction Required (Contract Non-Compliance)

For all cites in Section 18.5, please refer to the contract for all requirements between MCO and SCDHHS.

19.0 Terms and Conditions

19.1 General Contractual Condition

For all cites in Section 19.1, please refer to the contract for all requirements between MCO and SCDHHS.

19.2 HIPAA Compliance

For all cites in Section 19.2, please refer to the contract for all requirements between MCO and SCDHHS.

19.3 Safeguarding Information

For all cites in Section 19.3.1 through Section 19.3.1.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 19.3.1.3: On occasion MCOs must talk with authorized representatives and/or representative payee of a Medicaid beneficiary which were identified as part of the eligibility and Medicaid enrollment process. In these instances the MCO must speak with an authorized representative as long as their status can be validated. If SCDHHS, DSS clarifies as an employee they will be allowed access to information we have to be able to provide some specific identifying information regarding the beneficiary, examples may include name, date of birth, Medicaid ID.

If the MCO is unable to validate the status of an authorized representative and/or representative payee on their own the MCO should contact Medicaid beneficiary

services to determine the validity of an authorized representative and/or representative payee and must speak with those authorized representatives if beneficiary services confirms the validity of the information.

For all cites in Section 19.3.1.4 through Section 19.3.1.5, please refer to the contract for all requirements between MCO and SCDHHS.

19.4 HIPAA Business Associate

For all cites in Section 19.4, please refer to the contract for all requirements between MCO and SCDHHS.

19.5 Release of Records

For all cites in Section 19.5, please refer to the contract for all requirements between MCO and SCDHHS.

19.6 Confidentiality of Information

For all cites in Section 19.6, please refer to the contract for all requirements between MCO and SCDHHS.

19.7 Integration

For all cites in Section 19.7, please refer to the contract for all requirements between MCO and SCDHHS.

19.8 Hold Harmless

For all cites in Section 19.8, please refer to the contract for all requirements between MCO and SCDHHS.

19.9 Hold Harmless as to the Medicaid Managed Care Program Members

For all cites in Section 19.9, please refer to the contract for all requirements between MCO and SCDHHS.

19.10 Notification of Legal Action

For all cites in Section 19.10, please refer to the contract for all requirements between MCO and SCDHHS.

19.11 Non-Discrimination

For all cites in Section 19.11, please refer to the contract for all requirements between MCO and SCDHHS.

19.12 Safety Precautions

For all cites in Section 19.12, please refer to the contract for all requirements between MCO and SCDHHS.

19.13 Loss of Federal Financial Participation

For all cites in Section 19.13, please refer to the contract for all requirements between MCO and SCDHHS.

19.14 Sharing of Information

For all cites in Section 19.14, please refer to the contract for all requirements between MCO and SCDHHS.

19.15 Applicable Laws and Regulations

For all cites in Section 19.15, please refer to the contract for all requirements between MCO and SCDHHS.

19.16 Independent Contractor

For all cites in Section 19.16, please refer to the contract for all requirements between MCO and SCDHHS.

19.17 Governing Law and Place of Suit

For all cites in Section 19.17, please refer to the contract for all requirements between MCO and SCDHHS.

19.18 Severability

For all cites in Section 19.18, please refer to the contract for all requirements between MCO and SCDHHS.

19.19 Copyrights

For all cites in Section 19.19, please refer to the contract for all requirements between MCO and SCDHHS.

19.20 Subsequent Conditions

For all cites in Section 19.20, please refer to the contract for all requirements between MCO and SCDHHS.

19.21 Incorporation of Schedules/Appendices

For all cites in Section 19.21, please refer to the contract for all requirements between MCO and SCDHHS.

19.22 Titles

For all cites in Section 19.18, please refer to the contract for all requirements between MCO and SCDHHS.

19.23 Political Activity

For all cites in Section 19.23, please refer to the contract for all requirements between MCO and SCDHHS.

19.24 Force Majeure

For all cites in Section 19.24, please refer to the contract for all requirements between MCO and SCDHHS.

19.25 Conflict of Interest

For all cites in Section 19.25, please refer to the contract for all requirements between MCO and SCDHHS.

19.26 Department Policies and Procedures

For all cites in Section 19.26, please refer to the contract for all requirements between MCO and SCDHHS.

19.27 State and Federal Law

For all cites in Section 19.27, please refer to the contract for all requirements between MCO and SCDHHS.

19.28 Contractor's Appeal Rights

For all cites in Section 19.28, please refer to the contract for all requirements between MCO and SCDHHS.

19.29 Collusion/Anti-Trust

For all cites in Section 19.29, please refer to the contract for all requirements between MCO and SCDHHS.

19.30 Inspection of Records

For all cites in Section 19.30, please refer to the contract for all requirements between MCO and SCDHHS.

19.31 Non-Waiver of Breach

For all cites in Section 19.31, please refer to the contract for all requirements between MCO and SCDHHS.

19.32 Non-Assignability

For all cites in Section 19.32, please refer to the contract for all requirements between MCO and SCDHHS.

19.33 Legal Services

For all cites in Section 19.33, please refer to the contract for all requirements between MCO and SCDHHS.

19.34 Attorney's Fees

For all cites in Section 19.34, please refer to the contract for all requirements between MCO and SCDHHS.

19.35 Retention of Records

For all cites in Section 19.35, please refer to the contract for all requirements between MCO and SCDHHS.

DEFINITION OF TERMS

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

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.

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 the State; (5) The failure of the Contractor to act within the timeframes provided in §9.7.1 of 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 Contractor's network.

Additional Services – Services provided by MCO which are non-covered by the SCDHHS under the South Carolina State Plan for Medical Assistance.

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.

Applicant – An individual seeking Medicaid eligibility through written application.

Beneficiary – An individual who is Medicaid Eligible.

Capitation Payment – A payment SCDHHS makes periodically to the MCO on behalf of each MCO Medicaid Member enrolled under a contract for the provision of medical services under the South Carolina State Plan for Medical Assistance. SCDHHS makes the payment regardless of whether the particular MCO Medicaid Member actually receives services during the period covered by the payment.

Care Coordination – The manner or practice of planning, directing and coordinating health care needs and services of Medicaid MCO Members.

Certified Nurse Midwife/Licensed Midwife – A certified nurse midwife must be licensed and certified to practice as an advanced practice registered nurse by the Board of Nursing under the South Carolina Department of Labor, Licensing and Regulations. A licensed midwife is a layperson who has met the education and apprenticeship requirements established by DHEC.

Certified Registered Nurse Anesthetist (CRNA)/Anesthesiologist Assistant (AA) –

A CRNA must be licensed to practice as a registered nurse in the state in which he or she is rendering services **and** currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. An AA must be licensed to practice as an anesthesiologist assistant in the state in which he or she is rendering services. A CRNA is authorized to perform anesthesia services only and may work independently or under the supervision of an anesthesiologist.

CFR – Code of Federal Regulations.

Clean Claim – Claims that can be processed without obtaining additional information from the Provider of the service or from a third party.

CMS – Centers for Medicare and Medicaid Services

CMS 1500 (or its successor) – Universal claim form, required by CMS, to be used by non-institutional and institutional MCOs that do not use the UB-04 (or its successor).

Co-payment – Any cost sharing payment for which the Medicaid MCO Member is responsible for in accordance with 42 CFR § 447.50.

Cold-Call Marketing – Any unsolicited personal contact by the MCO with a potential member for the purpose of Marketing.

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.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) – A standardized survey of patients' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality.

Continuity of Care – Maintaining the same healthcare provider for (i) the continuous treatment for a condition (such as pregnancy) or (ii) duration of illness from the time of first contact with a healthcare provider through the point of release.

Contracted Provider – Providers that are licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency that have contracted with the MCO to provide health care services.

Core Benefits – A schedule of health care benefits provided to Medicaid MCO Members enrolled in the MCO's plan as specified under the terms of the Contract.

Covered Services – Services included in the South Carolina State Plan for Medical Assistance.

CPT – Current Procedural Terminology, most current edition.

DAODAS – South Carolina Department of Alcohol and Other Drug Abuse Services.

DHEC – South Carolina Department of Health and Environmental Control.

Direct Marketing – 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 MCO for the purpose of influencing an individual to enroll with the MCO's Managed Care Plan.

Disease Management – Activities performed on behalf of the members with special health care needs to coordinate and monitor their treatment for specific identified chronic/complex conditions and diseases and to educate the member to maximize appropriate self-management.

Disenrollment – Action taken by SCDHHS, or its Enrollment broker, to remove a Medicaid MCO Member from the MCO's plan following receipt and approval of a written Disenrollment request.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – A Program mandated by Title XIX of the Social Security Act in support of routine medical visits for one of the following: EPSDT visit, family planning, follow-up to a previously treated condition or illness, and/or any other visit for other than the treatment of an illness. Services are limited to beneficiaries from birth to the month of their 21st birthday.

Eligible(s) – A person whom has been determined Eligible to receive services as provided for in the South Carolina State Plan for Medical Assistance under Title XIX.

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.

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.

Encounter – Any service provided to a Medicaid MCO 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 the MCO contract.

Enrollment – The process by which a Medicaid Eligible selects or is assigned to an MCO.

External Quality Review (EQR) – The analysis and evaluation by an EQRO of aggregated information on Quality, timeliness, and access to the health care services than an MCO or its contractors furnish to Medicaid MCO Members.

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.

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

Federally Qualified Health Center (FQHC) – A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants.

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.

Grievance – A complaint, or 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.

HCPCS – CMS's Common Procedure Coding System.

Healthcare Medicaid Provider “Provider” – A provider of healthcare services or product which includes but is not limited to an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, or group or association approved by SCDHHS, licensed and/or credentialed which accepts payment in full for providing benefits to Medicaid MCO Member and is paid amounts pursuant to the MCO reimbursement provisions, business requirements and schedules.

Health Maintenance Organization (HMO) – A domestic licensed organization which 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.

Health Plan Employer Data and Information Set (HEDIS) – Standards for the measures set by the NCQA.

Health Insurance Protected Data Bank (HIPDB) – A national data collection Program for the reporting and disclosure of certain final adverse actions taken against health care practitioners, providers and suppliers. It is required to be performed by the MCO, or it's approved delegated credentialing entity, in the credentialing and recredentialing process outlined in this Policy and Procedure Guide and SCDHHS' contract requirement.

HHS – United States Department of Health and Human Services.

ICD – International Classification of Disease, Clinical Modification,

Incentive Arrangement – Any payment mechanism under which a MCO may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

Inmate – A person 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.

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 (ADLs). It is care or services provided in a facility that is licensed as a nursing facility, or hospital that provides swing bed or Administrative Days.

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a Comprehensive Risk Contract that is — (1) A Federally qualified HMO that meets the advance directive requirements of subpart I of 42CFR 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 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 Program offered by the MCO related to benefits to Medicaid Member.

Marketing – Any communication approved by SCDHHS from an MCO to an existing or potential Medicaid Recipient that can be 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 MCO Medicaid product.

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

Material Change – As applicable to contracts, a Material Change is one that is relevant and/or significant to the terms of the agreement as determined by one or both parties or SCDHHS.

Medicaid – The medical assistance Program authorized by Title XIX of the Social Security Act.

Medicaid Fraud Control Unit (MFCU) – A unit of the Attorney General's Office that investigates and prosecutes health care fraud committed by Medicaid providers and the physical abuse of patients and embezzlement of patient funds in facilities

Medical Doctor – An individual physician must be licensed by the Board of Medical Examiners, under the South Carolina Department of Labor, Licensing and Regulations.

Medicaid MCO Member – A Medicaid Eligible person(s) who is enrolled in an approved Medicaid MCO. For the purpose of this Policy & Procedure Manual and provider Subcontracts, a Medicaid MCO Member shall also include parents, guardians, or any other persons legally responsible for the member being served.

Medical Networks – An integrated delivery system of healthcare services, there can multiple Medical Networks in a county.

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 MCO, its Subcontractor, or any out of plan providers.

Medically Necessary Service – Those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid 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.

Medicare – A federal health insurance Program for people 65 or older and certain individuals with disabilities.

Member Handbook – The document which describes services and supplies provided to Medicaid MCO Members, which includes specific information on benefits, coverage limitations and services not covered.

MMIS – Medicaid Management Information System.

National Committee for Quality Assurance (NCQA) – A private, 501(c)(3) non-for-profit organization founded in 1990, dedicated to improve health care Quality.

National Practitioner Data Bank (NPDB) – A central repository for adverse action and medical malpractice payments which serves primarily as an alert or flagging system intended to facilitate a comprehensive review of a Health Care Provider's professional credentials.

NDC – National Drug Code.

Newborn – A live child born to a member.

Non-Contracted 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 MCO to provide health care services.

Non-Covered Services – Services not covered under the South Carolina State Plan for Medical Assistance.

Non-Emergency – An Encounter with a Health Care Provider by a Medicaid MCO Member who has presentation of medical signs and symptoms, that do not require immediate medical attention.

Nurse Practitioner and Clinical Nurse Specialist – A registered nurse must complete an advanced formal education program and be licensed and certified by the Board of Nursing under the Department of Labor, Licensing and Regulations. Services are limited by practice protocol.

Overpayment: Overpayment means that the provider was paid more for the service than allowed under the MCO's Medicaid payment rules. Overpayments can be caused by either Provider error or payer (MCO) error; are billing mistakes or reflect a misunderstanding as to the correct way to bill; can be caused by systems errors or failure to properly coordinate benefits with third parties; and do not indicate intent to defraud or abuse the Medicaid managed care program.

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).

Physician's Assistant – A physician assistant is defined as a health professional that performs such tasks as approved by the State Board of Medical Examiners in a dependent relationship with a supervising physician or under direct personal supervision of the attending physician.

Policies – The general principles by which SCDHHS is guided in its management of the Title XIX Program, as further defined by SCDHHS 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.

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

Primary Care Provider (PCP) – The Provider who serves as the entry point into the health care system for the member. The PCP is responsible for including 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 designated services as outlined in the MCO's Policy and Procedure Guide (Provider Manual).

Program – The method of provision of Title XIX services to South Carolina Recipients as provided for in the South Carolina State Plan for Medical Assistance and SCDHHS regulations.

Protected Health Information (PHI) – PHI means the same as the term protected health information in 45 CFR §160.103.

Quality – As related to External Quality Review, the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through structural and operational characteristics and through 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 Assurance – The process of assuring that the delivery of health care services provided to members are appropriate, timely, accessible, available and medically necessary.

Recipient – A person who is determined Eligible to receive services as provided for in the South Carolina State Plan for Medical Assistance.

Referral Services – Health care services provided to Medicaid MCO Members outside the MCO's designated facilities or its Subcontractors when ordered and approved by the MCO, 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.

Risk – A chance of loss assumed by the MCO which arises if the cost of providing Core Benefits and Covered Services to Medicaid MCO Members exceeds the Capitation Payment made by SCDHHS to the MCO under the terms of the contract.

Rural Health Clinic (RHC) – A South Carolina licensed rural health clinic is certified by the CMS and receiving Public Health Services grants.

Service Area – The geographic area in the state of South Carolina in which the MCO has been authorized by SCHHS for membership assignment and the provision of health care services to its membership.

South Carolina Department of Health and Human Services (SCDHHS) – SCDHHS and Department are interchangeable terms and definitions they are one in the same and one maybe be used to define the other in this document as well as in the MCO Contract.

SCDHHS 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. (1976, as amended).

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

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

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 MCO and a third party to perform a part of the MCO's obligations as specified under the terms of the Contract.

Subcontractor – Any organization, entity, or person who provides any functions or service for the MCO specifically related to securing or fulfilling the MCO's obligations to SCDHHS under the terms of the contract.

Surveillance and Utilization Review System (SURS) – A system approved by CMS that evaluates the utilization of health care services to identify suspected waste, fraud, and abuse by Providers or members in the Medicaid program. The SCDHHS Division of SURS carries out these functions using the business information analytics in the SURS.

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.

Targeted Case Management – Services which assist individuals in gaining access to needed medical, social, educational, and other services. Services include a systematic referral process to Providers.

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 MCO Member.

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

UB-04 (or its successor) – A uniform billing format for inpatient and outpatient hospital billing.

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 Added Items and Services (VAIS) – Items and services provided to a Medicaid MCO Member that are not included in the Core Benefits and are not funded by Medicaid dollars. SCDHHS only allows “healthcare-related” VAIS. Healthcare-related VAIS are items or services that are intended to maintain or improve the health status of Medicaid MCO Members.

APPENDIX 1 — Members' and Potential Members' Bill of Rights

Each Medicaid MCO Member is guaranteed the following rights:

1. To be treated with respect and with due consideration for his or her dignity and privacy.
2. To participate in decisions regarding his or her healthcare, including the right to refuse treatment.
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.
4. To be able to request and receive a copy of his or her Medical Records, and request that they be amended or corrected.
5. To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
6. To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
7. To receive all information including but not limited to Enrollment notices, informational materials, instructional materials, available treatment options, and alternatives in a manner and format that may be easily understood.
8. To receive assistance from both SCDHHS and the MCO in understanding the requirements and benefits of the MCO's plan.
9. To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
10. To be notified that oral interpretation is available and how to access those services.
11. As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and the MCO's responsibilities for Coordination of Care in a timely manner in order to make an informed choice.
12. To receive information on the MCO's services, to include, but not limited to:
 - a) Benefits covered
 - b) Procedures for obtaining benefits, including any authorization requirements
 - c) Any cost sharing requirements
 - d) Service Area
 - e) Names, locations, telephone numbers of and non-English language spoken by current contracted Providers, including at a minimum, primary care physicians, specialists, and hospitals.

- f) Any restrictions on member's freedom of choice among network Providers.
 - g) Providers not accepting new patients.
 - h) Benefits not offered by the MCO but available to members and how to obtain those benefits, including how transportation is provided.
13. To receive a complete description of Disenrollment rights at least annually.
 14. To receive notice of any significant changes in the Benefits Package at least thirty (30) days before the intended effective date of the change.
 15. To receive information on the Grievance, Appeal and Fair Hearing procedures.
 16. To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
 - a) What constitutes an Emergency Medical Condition, emergency services, and Post-Stabilization Services.
 - b) That Emergency Services do not require Prior Authorization.
 - c) The process and procedures for obtaining Emergency Services.
 - d) The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the contract.
 - e) Member's right to use any hospital or other setting for emergency care.
 - f) Post-Stabilization care Services rules as detailed in 42 CFR §422.113(c).
 17. To receive the MCO's policy on referrals for specialty care and other benefits not provided by the member's PCP.
 18. To have his or her privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.
 19. To exercise these rights without adversely affecting the way the MCO, its Providers or SCDHHS treat the members.

APPENDIX 2 — PROVIDERS' BILL OF RIGHTS

Each healthcare Provider who contracts with SCDHHS or subcontracts with the MCO to furnish services to the Medicaid Members shall be assured of the following rights:

1. A healthcare professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a Medicaid MCO Member who is his other patient, for the following:
 - a) The Medicaid MCO Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
 - b) Any information the Medicaid MCO Member needs in order to decide among all relevant treatment options
 - c) The risks, benefits, and consequences of treatment or non-treatment
 - d) The Medicaid MCO Member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions
2. To receive information on the Grievance, Appeal and Fair Hearing procedures.
3. To have access to the MCO's Policies and procedures covering the authorization of services.
4. To be notified of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
5. To challenge, on behalf of the Medicaid MCO Members, the denial of coverage of, or payment for, medical assistance.
6. The MCO's Provider selection Policies and procedures must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.
7. To be free from discrimination for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification

APPENDIX 3 — TRANSPORTATION BROKER LISTING AND CONTACT INFORMATION

<u>Broker: LogistiCare</u>	<u>Broker: LogistiCare</u>	<u>Broker: LogistiCare</u>
<p>If you live in one of these counties call: 1-866-910-7688</p> <p>Region 1</p> <p>Abbeville Anderson Cherokee Edgefield Greenville Greenwood Laurens McCormick Oconee Pickens Saluda Spartanburg</p>	<p>If you live in one of these counties call: 1-866-445-6860</p> <p>Region 2</p> <p>Aiken Allendale Bamberg Barnwell Calhoun Chester Clarendon Fairfield Kershaw Lancaster Lee Lexington Newberry Orangeburg Richland Sumter Union York</p>	<p>If you live in one of these counties call: 1-866-445-9954</p> <p>Region 3</p> <p>Beaufort Berkeley Charleston Chesterfield Colleton Darlington Dillon Dorchester Florence Georgetown Hampton Horry Jasper Marion Marlboro Williamsburg</p>