

SOUTH CAROLINA

Healthy Connections

MEDICAID



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

July 1, 2016

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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 General Administrative Requirements

For all cites in Sections 2.1.1 through Section 2.1.9, please refer to the contract for all requirements between MCO and SCDHHS.

Section 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.

Section 2.1.11: Include the contract requirement in the report required in 2.1.10.

2.2 Staffing Requirements

Section 2.2.1.1: Notification shall include a curriculum vitae for all key personnel, defined in the contract as management and having a designation on the table as 1.0 FTE. 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. No response from the department within 10 days of notification of change shall be considered approval of the key personnel assignment.

For all remaining cites in Section 2.2, please refer to the contract for all requirements between MCO and SCDHHS.

2.3 Training Requirements

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

2.4 Licensing Requirements

For all cites in Section 2.4, please refer to the contract for all requirements between MCO and SCDHHS.

2.5 Subcontracting and Delegation of Authority

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

2.6 Subcontract Boilerplate Requirements

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

Section 2.6.2: Should an MCO modify a previously approved direct service provision Subcontract or Boilerplate, it must submit a redline version of the document to SCDHHS for approval prior to execution by either party. The submission must be electronic and in the format required by SCDHHS. All revisions must be accompanied by a summary document explaining the change(s). The electronic redline contract submission must contain the following information:

- An electronic redline version of the Subcontract or Boilerplate 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 or Boilerplate 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 or Boilerplate 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.

For all cites in Sections 2.6.3 through Section 2.6.4, please refer to the contract for all requirements between MCO and SCDHHS.

2.7 Provider Subcontract Requirements

For all cites in Section 2.7, please refer to the contract for all requirements between MCO and SCDHHS.

2.8 Provider Enrollment and Credentialing

For all cites in Sections 2.8.1 through Section 2.8.2.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 2.8.2.4: Please refer to the contract for requirements between MCO and SCDHHS. The following guidance must also be referred to:

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.

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 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 MCO may delegate the credentialing and/or recredentialing process in accordance with SCDHHS contract and NCQA credentialing standards. MCOs are held accountable for ensuring delegated entities follow the requirements in accordance with SCDHHS contract and NCQA credentialing standards.

Re-credentialing for delegated entities will be completed no less than every three (3) years.

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

Whether the MCO does the initial credentialing/rec credentialing, 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

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 applicable 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 to practice by the appropriate / 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, Local Education Agencies, Rehabilitative Behavioral Health providers (public and private) and the Department of Disabilities and Special Needs, the MCO will credential the state agency/organization rather than the individual providers in the agency/organization.

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 2.8.3, please refer to the contract for all requirements between MCO and SCDHHS.

3.0 Member Eligibility and Enrollment

3.1 Member Eligibility

Section 3.1: The Healthy Connections State Plan, in accordance with federal requirements and state law and policy governs the enrollment of members into MCOs. Enrollment is limited to certain Medicaid beneficiaries who:

- Do not 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
- Do not have HMO third party coverage
- Are not otherwise excluded from participation based on federal requirements or state laws or policies

The table below reflects those eligibility categories that are mandatorily assignable (green), choice only (yellow), or non-managed care eligible (red).

Managed Care Eligibility and Eligibility Categories

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) (Age 19 and Above)
40	Working Disabled
59	Low Income Families
71	Breast and Cervical Cancer
80	SSI (Age 19 and Above)
87	OCWI Pregnant Women/Infants
88	OCWI Partners for Healthy Children
91	Ribicoff Children

Choice Only (MCO/FFS)	
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
	Members who are indians and part of a federally recognized tribe
FOST	Foster Care Children

Not Eligible to Participate with MCO	
10	MAO (Nursing Home)
14	MAO (General Hospital)
15	MAO (Waivers-Home and Community)
33	ABD Nursing Home
48	Qualified Individuals (QI)
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
VENT	Mechanical Ventilator Dependent Waiver
WMCC	Medically Complex Children's Waiver
MCHS	Hospice
	Members Eligible for Medicare
	Beneficiaries who have private managed care insurance (HMO)

3.2 Member Eligibility Redetermination

A file of members that will lose Healthy Connections Eligibility is created monthly from the SCDHHS Member Eligibility Systems. These files reflect those members whose Medicaid eligibility is due to end.

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

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

Both of these files are produced in the 3rd weekend of the month on Saturday and are available for the MCOs to retrieve on the following Monday.

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. Actions that are permitted include, but are not limited to, the following:

- MCOs can mail or give its member copies of the annual review form if the member indicates that he/she did not receive the original.
- MCOs can meet with its members to help complete forms.
- MCOs can provide stamped envelopes, or collect and mail completed forms on behalf of the member.
- MCOs can address a member listed on the redetermination file via phone calls, mailings, text messages or emails using address information from SCDHHS or provided directly by the member to the MCO if SCDHHS has approved message content.
- MCOs can notify primary care providers that a patient needs to renew.

A member of a household with multiple people covered by the same MCO can submit information for those other members with his/her review form, even if the other members were not listed on the review form. SCDHHS will update its records and these members may not need to submit a separate review at a later date. 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 seventy-five (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. The MCO may also encourage the member to contact the SCDHHS Member Services Call Center at 1-888-549-0820 for further assistance.

Member enrollment status may be tracked by the MCO using the following information provided by SCDHHS.

- Date of enrollment is included in daily and monthly 834 files (RSP-ELIG-DATE) and monthly MLE files (date of enrollment). A member must complete the review form by the review date listed on the redetermination report sent to the MCOs to avoid disenrollment. Review dates are no sooner than one (1) year after the date of enrollment.
- Medicaid eligibility status can be checked at any point using the eligibility web portal.

- Monthly redetermination files list members who will need to re-enroll within the next sixty (60) days.
- Members who have been successfully re-enrolled or dis-enrolled are included in both daily and monthly 834 files.
- MCOs are not notified if review forms have been received and are in process. However, the Medicaid call center can identify whether a review form has been received.

3.3 Member Enrollment

For all cites in Section 3.3, please refer to the contract for all requirements between MCO and SCDHHS.

3.4 Member Enrollment Process

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 3.4.4.

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 or its contracted enrollment broker.

Section 3.4.1 through Section 3.4.4: Member Enrollment Process (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 if that MCO is available in the beneficiary's county of residence. The enrollment will be effective on the first day of the next available enrollment period.
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. Previous enrollment will be considered before family member enrollment if both conditions are met.
3. Members that are not enrolled through one of the processes above will be assigned using the following Quality Weighted Assignment algorithm.

The Department will assign the Quality Weighted Assignment Factor based on the MCOs' South Carolina **overall rating** for NCQA's Medicaid Health Insurance Plan Ratings, as of November 1st of the preceding year. The MCOs' Quality Weighted Assignment Factor will be updated annually, effective for assignments beginning January 1st.

Quality Weighted Assignment Factors are assigned as listed below:

MCO HEALTH INSURANCE PLAN RATING	QUALITY WEIGHTED ASSIGNMENT FACTOR
1.0 or 1.5	0
2	0.5
2.5	0.75
3	1.0
3.5	1.25
4	1.5
4.5	1.75
5	2

The Quality Weighted Assignment algorithm will determine the number of members assigned to each plan, at the county level, as follows:

Step 1: Divide the total number of auto-assignable members for the enrollment period in the county by the sum of the Quality Weighted Assignment Factor for each MCO participating in the county.

Step 2: Multiply the result of step 1 by the Quality Weighted Assignment Factor for each MCO. This will result in the MCO's auto-assignment population for the enrollment period in each county.

Plans without a South Carolina overall rating published in the latest edition of NCQA's Medicaid Health Insurance Plan Ratings, as of November 1st of the preceding year, will be assigned a rating equal to the mode of the overall ratings of the South Carolina plans in the latest edition. If there are multiple modes, the median will be used instead. MCOs that receive a rating of "Partial Data Reported" or "No Data Reported" will be assigned a Quality Weighted Assignment Factor of 0, unless that rating was applied due to the MCOs lack of time in the South Carolina Medicaid market.

In the case of a merger or acquisition, the acquiring plan's Quality Weighted Assignment Factor will be applied, based on the methodology described above.

For all cites in Section 3.4.5 through Section 3.4.6, please refer to the contract for all requirements between MCO and SCDHHS.

3.5 Member Enrollment Effective Date

For all cites in Section 3.5, please refer to the contract for all requirements between MCO and SCDHHS.

3.6 Member Enrollment Effective Date

For all cites in Section 3.6, please refer to the contract for all requirements between MCO and SCDHHS.

3.7 Member Annual Re-Enrollment Offer

For all cites in Section 3.7, please refer to the contract for all requirements between MCO and SCDHHS.

3.8 Special Rules for the Enrollment of Newborns

Linked Newborn Enrollment – Retrospective:

Newborns linked to a mother that is enrolled in an MCO will be systemically enrolled retroactive to their birth month into the mother's MCO if all of the following exist:

- 1) The newborn was linked to an enrolled mother in the Medicaid eligibility system at the time the newborn eligibility transaction was initially sent to the Enrollment Broker.
- 2) The newborn eligibility transaction must have initially been sent to the Enrollment Broker during the first three months of the newborn's life.

Other Newborn Enrollment – Prospective:

Newborns that do not meet the criteria above will be sent to the Enrollment Broker for enrollment processing. Those newborns whose guardian chooses an MCO will be enrolled in the chosen MCO at the beginning of the next available enrollment period.

Newborns, whose guardian has not chosen an MCO by the enrollment deadline specified by the Enrollment Broker, shall be auto-assigned to an MCO effective at the beginning of the next available enrollment period. The Enrollment Broker will notify the MCO of all enrollments on daily and monthly 834 transactions.

Maternity Kicker Payments:

MCO maternity kicker payments for newborns enrolled in an MCO during the first three months of life will have the monthly automated maternity kicker payment calculated as part of the monthly automated/systemic capitation process.

To request payment 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>

The MCO is expected to work with the eligibility team to obtain accurate and complete information on newborns when this information is not known to the MCO.

Requests for manual maternity kicker payments may only be made between the fourth and sixth month after birth. The table on the following page below indicates for each birth month, when the manual maternity kicker payments may be submitted. 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.

In order to be processed as a manual maternity kicker for newborns and stillborns, the form must be completed as follows:

1. In months 1-5:
 - a. For newborns: All fields on the form must be completed for the mother AND the newborn. Entries that are incomplete will not be processed. The MCO will need to resubmit these entries in a subsequent acceptable period.
 - b. For Stillborns: All fields on the form must be completed for the mother and the date of birth must be completed for the stillborn. Encounter records will be used to validate these deliveries.

2. In month 6:

- a. For newborns: At a minimum, all fields for the mother must be completed and the child’s date of birth and sex must be completed.
 - i. SCDHHS will review the accepted encounter transactions for the mother in month 6 when the newborn’s name and Medicaid ID are not indicated on the maternity kicker payment notification log, searching for a diagnosis and/or a procedure code that indicates a delivery.
 - ii. SCDHHS will process any maternity kicker reported in month 6 when SCDHHS reviewed encounter records confirm the delivery.

MANUAL MATERNITY KICKER REQUEST SCHEDULE			
Birth Month	MK Auto Pay Months	Manual MK Request Months	Month Reports Received By SCDHHS
January	January February March	April May June	May June July
February	February March April	May June July	June July August
March	March April May	June July August	July August September
April	April May June	July August September	August September October
May	May June July	August September October	September October November
June	June July August	September October November	October November December

MANUAL MATERNITY KICKER REQUEST SCHEDULE			
Birth Month	MK Auto Pay Months	Manual MK Request Months	Month Reports Received By SCDHHS
July	July August September	October November December	November December January
August	August September October	November December January	December January February
September	September October November	December January February	January February March
October	October November December	January February March	February March April
November	November December January	February March April	March April May
December	December January February	March April May	April May June

3.9 Special Rules for Enrollment of American Indians

For all cites in Section 3.9, please refer to the contract for all requirements between MCO and SCDHHS.

3.10 Re-enrollment

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.

3.11 Maximum Member Enrollment

For all cites in Section 3.11.1, please refer to the contract for all requirements between MCO and SCDHHS.

3.12 Suspension and/or Discontinuation of Enrollment

For all cites in Section 3.12, please refer to the contract for all requirements between MCO and SCDHHS.

3.13 Member Disenrollment

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
- 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)]
- 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 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).

For all cites in Section 3.13.1 through Section 3.13.7, please refer to the contract for all requirements between MCO and SCDHHS.

3.14 Member Enrollment Information and Materials Requirements

For all cites in Section 3.14.1 through Section 3.14.4.9, please refer to the contract for all requirements between MCO and SCDHHS.

Section 3.14.5: 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.

3.15 Member Education

For all cites in Section 3.15, please refer to the contract for all requirements between SCDHHS and MCO.

3.16 Member Communication

For all cites in Section 3.16.1 through Section 3.16.1.1, please refer to the contract for all requirements between SCDHHS and the MCO.

Section 3.16.1.2 through Section 3.16.2.8: 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), 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 3.16.3.1 through Section 3.16.4, please refer to the contract for all requirements between SCDHHS and the MCO.

3.17 Member Rights

For all cites in Section 3.17, please refer to the contract for all requirements between SCDHHS and the MCO.

3.18 Member Responsibilities

For all cites in Section 3.18, please refer to the contract between SCDHHS and the MCO between MCO and SCDHHS.

3.19 Member Call Center

For all cites in Section 3.19.1 through Section 3.19.16.13, please refer to the contract for all requirements between MCO and SCDHHS.

Section 3.19.17 through Section 3.19.17.11: MCOs are required to submit monthly member and provider call center reports. These reports are reflected in the managed care report companion guide. MCOs shall submit these reports to the agencies SharePoint site in the MCO's monthly library.

4.0 Core Benefits and Services

4.1 General Core Benefits and Services Requirements

Section 4.1 through Section 4.1.6: 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.

MCO plans are required to provide Medicaid MCO Members “medically necessary” care, at the very least, at current limitations for the services listed below. 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/](https://www.scdhhs.gov/).

SCDHHS, 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.

4.2 Specific Core Benefits and Service Requirements

4.2.1 Abortions

The MCO shall cover abortions 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.

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.

1. Diagnosis codes to be used to report elective therapeutic abortions must be billed with ICD-10 diagnosis codes in the range of O04 through Z33.2.
2. 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.
3. 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.

4.2.2 Ambulance Transportation

All Advanced Life Support (ALS), Basic Life Support (BLS) and 911 based emergency transportation services provided via ambulance, air ambulance, and/or medivac 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.

4.2.3 Ancillary Medical Services

Ancillary medical services, including, but not limited to anesthesiology, pathology, radiology, emergency medicine, inpatient dental facility charges, outpatient dental facility charges and ambulatory surgical center charges for dental services, are part of the managed care organizations coverage array. When the Medicaid MCO Member is provided any of 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.

4.2.4 Audiological 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 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 bulletin.

4.2.5 Behavioral Health Services

MCO's are responsible for the full array of behavioral health services set forth in the following manuals:

- Autism Spectrum Disorder Manual
- Hospital Manual Services Provider Manual
- Licensed Independent Practitioner Manual
- Psychiatric Residential Treatment Services located in the Psychiatric Hospital Services Manual
- Physicians, Laboratories, and Other Medical Professionals Provider Manual

- Rehabilitative Behavioral Health Services Manual

These manuals can be found at <https://www.scdhhs.gov>.

MCO's are responsible for the full array of providers furnishing behavioral health services including but not limited to State agencies, 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 a Psychiatric Residential Treatment Facility (PRTF), 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 include all settings.

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 manuals reference above, 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.

PRTF Authorization and Members Relocating While Receiving PRTF Services

If a member moves from Fee-for-Service (FFS) Medicaid to an MCO or from one MCO to another MCO during an existing period of authorization for PRTF services, the MCO or FFS Medicaid receiving the member will honor the existing authorization in place until care coordination can be completed by the program receiving the member. The receiving entity will assess the members need for continuing treatment and the continued stay in the institutional setting will be assessed by the receiving entity.

The MCO that covers a Medicaid MCO Member on the day of admission to a PRTF is responsible for facility and ancillary charges associated with the time the member remains in the MCO. If the Medicaid MCO Member changes to another MCO or FFS Medicaid during the PRTF stay the new MCO or FFS Medicaid will be responsible for the institutional stay on the day that the member moves to the new MCO or FFS Medicaid. 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.

For example, an MCO (MCO1) member is admitted to a PRTF 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 and ancillary charges from the admission through August 31st. MCO2 is responsible for all facility and ancillary charges from September 1 through September 15th.

For all cites in Section 4.2.6 through Section 4.2.8, please refer to the contract for all requirements between MCO and SCDHHS.

4.2.9 Durable Medical Equipment (DME)

Durable Medical Equipment 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.

For all sites in Section 4.2.10 through Section 4.2.11, please refer to the contract for all requirements between MCO and SCDHHS.

4.2.12 Family Planning Services

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).

Detailed policy information regarding Family Planning can be found in the [Physicians, Laboratories, and Other Medical Professionals Provider Manual](#) at <https://www.scdhhs.gov/> and may be updated via Medicaid bulletins.

For all sites in Section 4.2.13, please refer to the contract for all requirements between MCO and SCDHHS.

4.2.14 Hysterectomies

The MCO shall cover 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 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 HHS-687) prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age. DHHS Form HHS-687 can be found in [Physicians Services](#) and [Hospital Services](#) provider manuals.

3. The form HHS-687 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 form HHS-687 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.

4.2.15 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.

4.2.16 Inpatient Hospital Services

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.

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

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. MCO Managed Care staff will work in conjunction with SCDHHS to ensure timely identification of persons certified to enter long-term care facilities/nursing homes.

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.

4.2.18 Maternity Services

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.

4.2.19 Outpatient Services

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.

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.

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

4.2.20 Physician Services

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/>.

4.2.21 Pharmacy / 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

For all cites in Section 4.2.21.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 4.2.21.2: 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. 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.

For all cites in Section 4.2.21.3 through Section 4.2.22.2, please refer to the contract for all requirements between MCO and SCDHHS.

Medication Assisted Therapy

Effective for dates of service on or after August 1, 2017, MCOs must cover at least one (1) of the therapeutic options from the buprenorphine/naloxone medication class and must be covered without prior authorization. The availability of this medication must be indicated on the MCO's preferred drug list. The MCO may continue to apply coverage restrictions that are consistent with the product's FDA label.

Tobacco Cessation Coverage

Effective July 1, 2017, all FDA-approved tobacco cessation medications must be available without member cost share or prior authorization. Medications subject to these requirements include: bupropion for tobacco use (Zyban), varenicline (Chantix), and nicotine replacement therapies in gum, lozenge, nasal spray, inhaler, and patch dosage forms. General benefit edits related to day supply limits should continue to be enforced. However, limits related to age, quantity, or number of quit attempts must not be more restrictive than the FDA labeling.

The following medically appropriate combination therapies must also be covered:

- Long-term nicotine patch + other NRT product (gum or spray)
- Nicotine patch + nicotine inhaler
- Nicotine patch + Bupropion SR

Override/Early Refill Requirements Long Term Care Facilities

Outside medications are not typically allowed into Long Term Care (LTC) and Psychiatric Residential Treatment Facility (PRTF) facilities. When admission to either a Long Term Care (LTC) and/or Psychiatric Residential Treatment Facility (PRTF) occurs for a managed care member, the MCO must allow an override/early refill for their member(s) to ensure continuity of care regarding prescription medications.

4.2.23 Rehabilitative Therapies for Children – Non-Hospital Based

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.

4.2.24 Substance Abuse

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.

4.2.25 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, Allogeneic 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 medically 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.

For all cites in Section 4.2.26, please refer to the contract for all requirements between MCO and SCDHHS.

4.2.27 Sterilization

The MCO shall cover sterilizations 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.

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 one hundred eighty (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 Consent for Sterilization form (SCDHHS Form HHS-687) for Medicaid beneficiaries.

For all cites in Section 4.2.28, please refer to the contract for all requirements between MCO and SCDHHS.

4.3 Additional Services

For all cites in Section 4.3.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 4.3.2 through Section 4.3.4: 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. Please see the current MCO Report Companion Guide for the *Additional Services Request Form* required report format for requesting additional services.

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.

For all cites in Section 4.3.5, please refer to the contract for all requirements between MCO and SCDHHS.

Section 4.3.6: 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. Requested changes must be submitted to SCDHHS by October 15th for insertion into the Enrollment Broker's materials in January and by March 15th for insertion into the Enrollment Broker's materials in July. All requested changes must be approved by SCDHHS prior to insertion. 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 4.3.7 through Section 4.3.7.3, please refer to the contract for all requirements between MCO and SCDHHS.

4.4 Excluded Services

For all cites in Section 4.4.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 4.4.2: 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.

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 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.

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 services through the Medicaid fee-for-service program. 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.

4.5 Medical Necessity Determination

For all cites in Section 4.5 please refer to the contract for all requirements between MCO and SCDHHS.

4.6 Out-of-Network Coverage

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

4.7 Second Opinions

For all cites in Section 4.7, please refer to the contract for all requirements between MCO and SCDHHS.

4.8 Member Incentives

Section 4.8.1: 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 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.

For all cites in Section 4.8.2 through Section 4.8.7, please refer to the contract for all requirements between MCO and SCDHHS.

4.9 Moral and Religious Objection

For all cites in Section 4.9, please refer to the contract for all requirements between MCO and SCDHHS.

5.0 Care Management and Coordination

5.1 General Care Management and Coordination Requirements

For all cites in Section 5.1, please refer to the contract for all requirements between MCO and SCDHHS.

5.2 National Standards Requirements

For all cites in Section 5.2, please refer to the contract for all requirements between MCO and SCDHHS.

5.3 Member Risk Stratification Requirements

For all cites in Section 5.3, please refer to the contract for all requirements between MCO and SCDHHS.

5.4 Member Risk and Care Management Activity Requirements

For all cites in Section 5.4 through Section 5.4.5.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 5.4.5.1: 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.

5.5 Continuity of Care Management Activities

Section 5.5.1.1: 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 5.5.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 5.5.3 through Section 5.5.5.2.2: All MCOs are responsible for coordinating their members care and providing necessary case management functions. Case management and care coordination functions continue even if the service is outside of the MCO's core benefit package outlined in section 4 of the contract and MCO policy and procedure guide.

If it is discovered during care management and treatment that an MCO member would benefit from:

1. Excluded behavioral health services offered in FFS Medicaid.
2. Out of state organ transplantation services (See section 4 above).
3. Out of state Non-Emergency Medical Transportation is requested by the member for services that the MCO's medical director deems medically necessary.

The MCO must provide the SCDHHS medical directors with the information listed in A-D below in order for SCDHHS to render a final decision on Medicaid FFS coverage for the services listed above.

- A. All current physical health medical records for the member needing additional benefits not offered through the MCO's core benefit package.
- B. All current behavioral health medical records for the member needing additional benefits not offered through the MCO's core benefit package.
- C. Summary of the presenting issues that have lead the MCO and its medical director to request services beyond the core Medicaid managed care benefit package.

- D. Conclusions and a recommendation to the SCDHHS medical directors regarding the medical necessity of the care being requested via FFS Medicaid by the MCO's medical director.

MCOs may contact their managed care program liaisons at SCDHHS if they need assistance in contacting one of the SCDHHS medical directors.

Section 5.6 through Section 5.6.6.1.4, please refer to the contract for all requirements between MCO and SCDHHS.

Section 5.6.6.2: 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 5.6.6.3 through Section 5.6.6.5, please refer to the contract for all requirements between MCO and SCDHHS.

6.0 Networks (Provider Network Requirements)

For all cites in Section 6.1.1 through Section 6.1.11, please refer to the contract for all requirements between MCO and SCDHHS.

6.2 CONTRACTOR Provider Network

Section 6.2: 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.

Sections 6.2.1 through Section 6.2.4.1: 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: OBs acting as a primary care physician should be included in the PCP section of the Geo-coded report. Also include all OB/GYNs in the specialty section of the Geo-coded report.
4. FQHC/RHC: FQHC and RHC Providers acting as PCP must be included in the PCP section of the Geo-coded report. FQHC and RHC Providers acting as specialists must be included in the appropriate required specialty Geo-coded 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 below). 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. Geo-coded reports must be uploaded to the MCO's SharePoint Required Submissions library.

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

NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE	STATUS	SCDHHS COMMENTS
Endocrinology and Metab	3	
Gastroenterology	1	
SPECIALISTS		
Hematology/Oncology	1	
Infectious Diseases	1	
Licensed Mental Health Professionals	1	These include the following: <ul style="list-style-type: none"> • Licensed Independent Social Worker • Licensed Marriage & Family Therapist • Licensed Psycho-Educational Therapist
Neonatology	3	
Nephrology	1	
Neurology	1	
Nuclear Medicine	3	
OB/GYN	1	
Ophthalmology	1	
Optician	4	
Optometry	1	
Orthopedics	1	
Otorhinolaryngology	1	
Pathology	3	
Pediatrics, Allergy	3	
Pediatrics, Cardiology	3	
Podiatry	3	
Psychiatry (private)	1	
Psychologist	1	
Pulmonary Medicine	1	
Radiology, Diagnostic	3	

NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE	STATUS	SCDHHS COMMENTS
Radiology, Therapeutic	3	
Rehabilitative Behavioral Health	1	
Rheumatology	3	
Surgery – General	1	
Surgery – Thoracic	3	
Surgery – Cardiovascular	3	
Surgery - Colon and Rectal	3	
Surgery – Neurological	3	
Surgery – Pediatric	3	
Surgery – Plastic	3	
Therapy-Occupational	1	
Therapy-Physical	1	
Therapy-Speech	1	
Urology	1	
Long-Term Care	3	MCO responsibility begins once the Medicaid MCO Member has been approved for, and admitted to the LTC facility. If the Medicaid MCO Member stays in the facility for 90 consecutive days, the Medicaid MCO Member will be disenrolled from the MCO at the earliest opportunity by SCDHHS. The MCO financial responsibility will not exceed 120 days total.
Status	1 = Required 2 = Not required unless serving as PCP for the county 3 = Attestation 4 = Attest, if offered	

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 Geo-coded 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 Geo-coded 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.

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 Provider Network Submission

Section 6.3.1: 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.

For all cites in Section 6.3.2 through Section 6.3.3.3, 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 Medical Loss Ratio (MLR)

For all cites in Section 7.2.1 through Section 7.2.1.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 7.2.1.3: Additional guidance to be added at a later date.

For all cites in Section 7.2.1.4 through Section 7.2.4, please refer to the contract for all requirements between MCO and SCDHHS.

7.3 Capitation Payments from the Department to CONTRACTOR

Section 7.3.1.1: SCDHHS uses an actuarially sound methodology to develop its managed care rates. These methodologies can be found in the Managed Care Rate Book on the SCDHHS website, <https://msp.scdhhs.gov/>.

While the majority of payments made are automated capitation payments some may be paid to the MCO through an adjustment process. 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 ‘gross level’ 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.

SCDHHS wherever able will process adjustments at the individual premium level but the following payments and/or debits may 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.

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 will be paid through gross level adjustment after a quarter has ended.

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 the application process cannot exceed eighteen (18) months. If SCDHHS, at its discretion, determines the application documentation on file with 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.
- **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.
 - PCMH incentive payments apply to all in-state Medicaid enrolled providers who achieve PCMH recognition. In-state Medicaid enrolled providers are defined as any one residing with-in the state or within 25 miles of the South Carolina state border.
 - 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.

- All PCMH reporting should be submitted in the MCOs SharePoint site monthly in the library labeled NCQA PCMH Data. PCMH reporting must have the following naming conventions:

Regular Submission:

PlanName_PCMH_FY#_Qtr#_Month

Example: If the submission is for the February 2016 PCMH data submission, the file name would be: **ACMEMCO_PCMH_FY2016_Qtr3_February.**

Retro Submission:

PlanName_PCMH_FY#_Qtr#_Month_Retro

Example: If the submission is for a retroactive submission of PCMH data for October 2016 PCMH data submission, the file name would be: **ACMEMCO_PCMH_FY2016_Qtr2_October_Retro.**

Corrected files should be resubmitted within the same quarter, if at all possible. If submitted after the 15th of the last month of a quarter, these corrected files will be processed for payment during the next quarter. Retroactive requests and corrected files may only be backdated one quarter. SCDHHS will not pay MCOs for retroactive PCMH data outside of the prior quarter. This allows 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.

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.

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 three (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 section three (3) 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 after a full quarter of premium payments have been processed by the SCDHHS. Withhold methodology will be based on the table within the annual rate book issued by Milliman and approved by SCDHHS that is labeled Capitation Rate Change by Rate Cell. The rates reflected in the section of this table labeled Excluding Supplemental Teaching Payments will be multiplied by the risk score and the total number of members in each rate cell for each MCO. SCDHHS will then multiply this total value by 1.5% to derive the final withhold for each MCO for the quarter.

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 7.3.1.2 through Section 7.3.3.3, please refer to the contract for all requirements between MCO and SCDHHS.

7.4 Payments from CONTRACTOR to Subcontractors

For all cites in Section 7.4.1 through 7.4.2.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 7.4.2.3: 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 Rural Health Clinic (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.

The Medicaid MCO shall submit a report, quarterly, to its SharePoint quarterly library, all paid encounter/claim data, by date of service, for all services rendered by RHCs for supplemental payment determination (Wrap-Around methodology) reconciliation purposes. Services eligible for Wrap-around methodology must meet fee-for-service coverage requirements. The Contractor shall submit the name of each RHC and detailed Medicaid encounter data paid to each 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.

Based on the RHC's fiscal year end, an annual reconciliation of MCO payments and services to allowable reimbursement based on the 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 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 RHC and detailed Medicaid encounter data (i.e. Medicaid recipient data, payment data, service/CPT codes) paid to each 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>.

The Contractor shall submit the name of each RHC and detailed Medicaid claims/encounter data (i.e., Medicaid recipient data, payment data, service/CPT codes) paid to each RHC by month of service to the Department for federally mandated reconciliation and auditing purposes. Encounter detail data and summary data shall be provided to SCDHHS as two (2) separate data spreadsheets in one Microsoft Excel workbook. 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>.

For all cites in Section 7.4.3 through Section 7.4.3.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 7.4.3.2: 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 or its contractors 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.

Beginning with dates of service on or after July 1, 2016, new contractual requirements include Prospective Payment System (PPS) methodology for FQHC providers. MCOs must pay FQHC providers based on the methodology reflected in the table below.

Managed Care Organizations Policy and Procedure Guide

WRAP PAYMENT METHODOLOGY	
EFFECTIVE JULY 1, 2017	
FQHC	
Allowed CPT Codes (1)	Exclusions from FQHC Encounter Rate (3)
Billable as a Medical Encounter:	59025 (TC Modifier)
T1015	70000 - 79999 (TC Modifier)
99201-99205	70000 Series - 70% removed for Tech component (4)
99212-99215	90378
99241-99245	90630
99381-99385	90656
99391-99395	90657
Add. Codes for Bi-Annual Exams (Adults):	90658
99386	90620, 90621, 90670
99387	90662
99396	90672
99397	90673
Podiatry:	90685-90688
Standard E&M codes - see above	90707, 90710, 90715, 90716
Ophthalmology:	90732
92002	92250/TC
92004	92340
92012	93005
92014	93017
Chiropractic:	93041
98940-98942	93225
In-Home Services	93325
99341-99345	93880
99347-99350	93970
Domiciliary or Rest Home Services:	99050
99324-99328	99051
99334-99337	99217 - 99999 *
Skilled Nursing Facility Services:	A4264
99304-99310	J1050
99315-99316	J1950
99318	J7297
Family Planning Service (separate visit):	J7298
99401-99402	J7300
Postpartum Care:	J7301
59430	J7307
Health Risk Assessment (Foster Care):	80305
96160, 96161	80307
MNT/Nutritional Counseling/Obesity Initiative:	G0480
97802-97803	Q2035 - Q2039
	Q3014
Billable as a Behavioral Health Encounter: (2)	
90791, 90792	
90832-90834, 90836-90838	
90839	
90847, 96101	
T1015/HE	
* - Any code in this range unless included in the "Allowed CPT Code" column.	
FOOTNOTES	
(1) Allowed CPT Codes are those services considered as an eligible FQHC encounter service. They are includable in the WRAP "count".	
(2) Behavioral Health Services codes that are considered as an eligible FQHC encounter. A behavioral health code can be provided and billed on the same date of service as a medical service. Both services/encounters will be included in the WRAP settlement.	
(3) Excludable procedure codes billed under MCO arrangements are not includable in the WRAP payment calculations and thus are carved out and reimbursed separately outside of the FQHC encounter rate. For any procedure code billed outside of those identified under sections (1), (2), and (3), payment of these codes are included in the FQHC encounter service rate and thus should not be separately reimbursed.	
(4) The professional component of the 70000 series procedure codes are included in the FQHC encounter service rate and thus should not be separately reimbursed.	
5) Current policy allows dietitian services as incident to a physician or mid-level service. That is, the beneficiary is seen by the provider (physician or mid-level) and dietitian on the same day, one encounter can be billed for the services received that day. Dietitian services cannot be billed independently from the services of the physician or mid-level.	
6) Group services should never be billed using the encounter rate. A billable encounter is a face-to-face, one-on-one service with a physician or mid-level practitioner.	
7) Procedure codes will be reviewed annually to determine if updates are required in either billable encounter codes or excludable services.	

PPS ARM rate reimbursements were shared with all MCO's June 13, 2016. This document indicates all current encounter reimbursement rates that must be paid and the FQHCs eligible for this reimbursement methodology. MCOs and FQHCs through their contractual relationship determine when full payment is made for services rendered by the FQHC. Departmental preference is for full payment initially when the FQHC provides services. SCDHHS understands that reconciliation at a later date may initially be necessary while claims processing systems are modified to address claims payment logic. MCOs should only pay for codes that are reflected in the reimbursement methodology chart reflected above.

MCO Encounter Submission of FQHC Data

SCDHHS can capture encounters with zero line payments. If the MCO encounter submission includes all applicable coding with no payment or with the FFS payment for codes reflected in the chart above as excluded from the FQHC encounter rate the department will be able to accept and process the encounter.

Reporting Requirement

The Medicaid MCO shall submit a report, quarterly, to its SharePoint quarterly library, all paid encounter/claim data, by date of service, for all services rendered by FQHCs for review and agency auditing purposes to confirm the entire encounter rate was paid to all participating FQHCs. The Contractor shall submit the name of each FQHC and detailed claims/encounter data paid to each FQHC. 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 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'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 claims data not available or processed when the applicable quarter was originally run.

Transmission requirements remain the same as the 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 and detailed Medicaid claims/encounter data (i.e., Medicaid recipient data, payment data, service/CPT codes) paid to each FQHC by month of service to the Department for federally mandated reconciliation and auditing purposes. Encounter detail data and summary data shall be provided to SCDHHS as two (2) separate data spreadsheets in one Microsoft Excel workbook. 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>.

For all cites in Section 7.4.3.3 through Section 7.4.3.4, please refer to the contract for all requirements between MCO and SCDHHS.

7.5 Co-payments

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.

Medicaid copayments only apply for the following provider types and services:

APPLICABLE COPAYMENTS BY PROVIDER TYPE AND SERVICE CODE			
Service Provider	Applicable Codes	Provider Type	Copay Values
Pharmacy	Per Script (exclusions apply)	70	\$3.40
Physician Services	90791-90792	20,21	\$3.30
Physician Services	92002-92014	20,21	\$3.30
Physician Services	99201-99205	20,21	\$3.30
Physician Services	99212-99215	20,21	\$3.30
Physician Services	99241-99245	20,21	\$3.30
Podiatry Services	99201-99205	20,21	\$1.15
Podiatry Services	99212-99215	20,21	\$1.15
Podiatry Services	99241-99245	20,21	\$1.15
Optometry Services	92002-92014	33, 34	\$3.30
Optometry Services	99201-99205	33, 34	\$3.30
Optometry Services	99212-99215	33, 34	\$3.30
Optometry Services	99241-99245	33, 34	\$3.30
Chiropractor Services	98940	37, 38	\$1.15
Chiropractor Services	98941	37, 38	\$1.15
Chiropractor Services	98942	37, 38	\$1.15
Nurse Practitioners/Physician Assistants	90791-90792	19 (PS=86, PA)	\$3.30
Nurse Practitioners/Physician Assistants	92002-92014	19 (PS=86, PA)	\$3.30
Nurse Practitioners/Physician Assistants	99201-99205	19 (PS=86, PA)	\$3.30
Nurse Practitioners/Physician Assistants	99212-99215	19 (PS=86, PA)	\$3.30
Nurse Practitioners/Physician Assistants	99241-99245	19 (PS=86, PA)	\$3.30
Ambulatory Surgery Clinic	Svc Per Day	22	\$3.30
Federally Qualified Health Centers	Encounter	22	\$3.30
Home Health Services	S9128	60	\$3.30
Home Health Services	S9129	60	\$3.30
Home Health Services	S9131	60	\$3.30
Home Health Services	T1021	60	\$3.30
Home Health Services	T1028	60	\$3.30
Home Health Services	T1030	60	\$3.30
Home Health Services	T1031	60	\$3.30
Rural Health Clinics	Encounter	22	\$3.30
Dental	Per day/Service	30	\$3.40
Durable Medical Equipment	Per Item	76	\$3.40
Outpatient Hospital Non Emergent Services	Per Claim	02	\$3.40
Inpatient Hospital	Per Admission	01	\$25.00

7.6 Emergency Services

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

7.7 Payment Standards

For all cites in Section 7.7, please refer to the contract for all requirements between MCO and SCDHHS.

7.8 Prohibited Payments

For all cites in Section 7.8, please refer to the contract for all requirements between MCO and SCDHHS.

7.9 Periodic and Annual Audits

Section 7.9.1: The annual audited financial report should be the same report submitted to the South Carolina Department of Insurance (SCDOI) in June and follow SCDOI regulation 69-70, Annual Audited Financial Reporting Regulation.

7.10 Return of Funds

For all cites in Section 7.10, please refer to the contract for all requirements between MCO and SCDHHS.

7.11 Medicaid Provider Tax Returns

For all cites in Section 7.11, please refer to the contract for all requirements between MCO and SCDHHS.

8.0 Utilization Management

8.1 General Requirements

For all cites in Section 8.1, please refer to the contract for all requirements between 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 Contractor Utilization Management (UM) Program Reporting Requirements

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

8.4 Practice Guidelines

For all cites in Section 8.4, please refer to the contract for all requirements between MCO and SCDHHS.

8.5 Service Authorization

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

8.6 Timeframe of Service Authorization Decisions

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

8.7 Exceptions to Service Authorization Requirements

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

8.8 Emergency Service Utilization

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 and Provider Disputes

The MCO must upload their written beneficiary grievance, appeal and provider dispute 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.

9.1 Member Grievance and Appeal System

For all cites in Section 9.1 through Section 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

For all cites in Section 9.1.3.1 through Section 9.1.3.1.1: Provides to SCDHHS on a quarterly basis an appeal log and a grievance log for all appeals and grievances that occurred during each month of the reporting quarter to include:

- A general description of the reason for the appeal or grievance
- The date received
- The date of each review or, if applicable, review meeting
- Resolution at each level of the appeal or grievance, if applicable
- Date of resolution at each level, if applicable
- Name of the covered person for whom the appeal or grievance was filed
- Corrective Action, if applicable

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

For all cites in Section 9.1.4 through Section 9.1.6.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 9.1.6.1.1 through Section 9.1.6.1.5: Disposition of a written grievance will be communicated to the Medicaid member with written correspondence delivered first class, utilizing the United States Postal System (USPS). Grievances submitted orally may be responded to either orally or in writing, unless the member requests a written response.

For all cites in Section 9.1.6.2 through Section 9.1.6.3.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 9.1.6.3.1.1: 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 one hundred and twenty (120) days of the delivery of the denial notice. The date of the return receipt will begin the one hundred twenty (120) 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 one hundred and twenty 120-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.

A MCO member or a provider/responsible party acting on the member's behalf may request an expedited State Fair Hearing. SCDHHS will grant or deny these requests for a State Fair Hearing as quickly as possible. If SCDHHS grants the request to expedite, the appeal will be resolved as quickly as possible instead of the standard 90-day timeframe. If SCDHHS denies the request to an expedited State Fair Hearing, the appeal will follow the standard 90-day timeframe.

SCDHHS may grant an expedited State Fair Hearing review if it is determined the standard appeal timeframe could jeopardize the individual's life, health, or ability to attain, maintain, or regain maximum function. SCDHHS may consider, among other facts:

- The medical urgency of the beneficiary's situation
- Whether a needed procedure has already been scheduled
- Whether a beneficiary is unable to schedule a needed procedure due to lack of coverage
- Whether other insurance will cover most of the costs of the requested treatment

MCO members or a provider/responsible party may request an expedited State Fair Hearing at the same time they file an appeal with SCDHHS or after the MCO member or provider/responsible party files the appeal with SCDHHS. Members and/or providers

must state in the request their desire for an expedited State Fair Hearing and explain the reasons for the expedited request.

To avoid delays in the expedited State Fair Hearing review process, MCO members or their provider/responsible party acting on their behalf should submit any supporting documentation with the request for expedited review or immediately thereafter. While supporting documentation is not required, SCDHHS will make its determination based on the information made available at the time we consider the request.

For all cites in Section 9.1.6.3.1.2 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 through Section 9.2.7, please refer to the contract for all requirements between MCO and SCDHHS.

Section 9.2.8: MCO provider dispute policies and procedures must be uploaded to the MCOs SharePoint site in the Required Documents library annually.

For all cites in Section 9.2.8.1 through Section 9.2.15, please refer to the contract for all requirements between MCO and SCDHHS.

Section 9.2.16: Provides to SCDHHS on a quarterly basis written summaries of the Provider 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. Therefore, 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: 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 10.4.3: 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 MCO must perform cost avoidance whenever it has knowledge of a responsible third party payer except in the instances described below. 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.

Section 10.4.4: 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.

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.

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.

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: 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 10.9.1 through Section 10.9.1.4: MCOs must report submit five (5) TPL reports to SCDHHS on a monthly basis.

1. **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. **Coordination of Benefits (COB) Savings:** This report consists of all claims during the month that have been identified as having third party coverage leading to coordination of benefits savings for the MCO. The coordination of benefits savings is defined as the amount saved because primary health insurance paid on the claim. 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 charge, practice specialty description, primary health insurance payment, primary health insurance carrier code and claim paid amount.
4. **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.
5. **Casualty Claims:** This report consists of all claims during the month that have been identified as the responsibility of a third party payer and the MCO has paid the claims. This report should be broken into open cases, closed cases and the number of case lead types received (ex. questionnaires, attorney letters, provider

letters, insurance letters and the number of those case leads that resulted in an open or closed case). The report will be uploaded to the MCO's SharePoint monthly library and will contain the following data elements for open cases: Medicaid member ID, first name, last name, date of injury, name of liable party, date of lien notice sent, name of attorney/insurance company, case status, settlement amount, recovered amount, dated closed and the following elements for closed cases: Medicaid member ID, first name, last name, reason for close, recovered amount and date closed.

11.0 Program Integrity

11.1 General Requirements

Unless otherwise specified below, refer to Section 11.1 of the Contract for all requirements between MCO and SCDHHS.

The Department's Fraud Hotline is organized within the Division of Program Integrity/SUR (PI), Department of Recipient Utilization (DRU) to accept tips and complaints from all sources concerning Provider and Member potential *fraud*, waste, and abuse (FWA) that may be occurring in the SC Medicaid Program. Refer to Section 11.1.10 of this document for Member investigations of potential fraud.

Section 11.1.1: Refer to Section 11.2, Compliance Plan Requirements, of this document.

Section 11.1.2: Refer to Section 2.2, Staffing Requirements, of the Managed Care Contract.

For all cites in Section 11.1.3 through Section 11.2.9, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.1.10: The MCO shall promptly perform a preliminary investigation of all complaints and allegations of suspected fraud and abuse against Providers or Members.

If the MCO identifies conduct that it reasonably believes constitutes a violation of State or Federal law concerning Medicaid fraud involving a Provider or a Member, then a fraud referral must be reported to PI and MFCU within one (1) business day of discovery by using the appropriate Provider or Member Fraud and Abuse Referral Form for Managed Care Organizations located on the secure PI website (see the Report Companion Guide for the Fraud and Abuse Referral Form).

In cases where a fraud referral has been made, the MCO is not permitted to take any actions based on the review findings, including, but not limited to, recoupments, reviews, or further investigation, without prior written approval from SCDHHS PI. Additionally, the MCO is not permitted to disclose to the provider at any time during the course of the review, that there is a suspicion of fraud or that a referral has been made.

PI manages the organization, content and structure of the secure PI website. The Department utilizes Microsoft's SharePoint as the current method of exchange to facilitate file transfers, information sharing and monthly and quarterly reporting between the MCO and the Department.

All Fraud Referrals by the MCO to the Department must include the Fraud Referral Form (see the Report Companion Guide for the Fraud and Abuse Referral Form) and be accompanied by the MCO's complete investigative file, including but not limited to as applicable, preliminary investigation results, interviews, all records or documents collected, line by line review findings that substantiate any under or overpayment, evidence supporting a credible allegation of fraud, reviewer/investigative notes, provider enrollment and credentialing documents, phone log, related complaints, related data analysis, copies of provider remittance advice, and any applicable repayment history.

Fraud and Abuse Indications

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

A. For Providers/Subcontractors:

- There is no documentation of 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 record include, but are not limited to, service notes, prior authorization and medical necessity statements, diagnostic reports, and any other documentation that establishes the scope, duration, and medical necessity for the service provided.
- Billing for services, supplies or equipment that were not rendered or provided to Medicaid members.
- Evidence of manufactured or altered documentation, or forged signatures.
- The Provider has engaged in unallowable marketing and/or patient recruitment.
- An excluded/terminated individual, or a Provider not enrolled or contracted with a plan, bills under another Provider's NPI.
- Material misrepresentation of dates, description of services, the identity of the individual rendering the services, or the recipient of the services.
- Billing an unreasonable or improbable number of units or services (Time Bandit).
- Billing an unreasonable or excessive amount of supplies, or supplies and equipment that is clearly unsuitable for the patient's needs, or so lacking in quality or sufficiency to be deemed virtually worthless.
- Procedure codes or services do not correspond with Provider type.

- Procedure codes, services, or 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 overpayment to the Provider.
 - There are significant unexplainable and/or unreasonable spikes in the volume of claims and reimbursement.
 - Billing for diagnostics, "special studies" and exotic tests with no documentation for medical necessity.
 - Other indications of fraud described by the MCO making the referral.
- B. For Members the MCO must report fraud and/or abuse to the DRU when any of the following indications are present:
- Suspicion that a Member submitted a false application to Medicaid.
 - Upon discovery that a Member provided false or misleading information about family group, income, assets and/or resources, or any other information in order to gain eligibility for benefits.
 - Indication of Medicaid card sharing with other individuals.
 - A Medicaid card was bought or sold.
 - Member engaged in selling of prescription drugs, medical supplies, or other benefits.
 - Member 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 PI, using the appropriate Provider or Member Fraud and Abuse Referral Form for Managed Care Organizations located on the PI secure website (see the Report Companion Guide for the Fraud and Abuse Referral Form). After completing the form on the secure PI website, it must be transmitted using the SUBMIT button. The MCO must also notify the Department's MCO PI Coordinator by email indicating the referral form was transmitted. The referral will be logged as a complaint by the PI 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 and access to records, and access to interview MCO's employees and consultants, including but not limited to those with medical or pharmaceutical expertise in the administration of the program, or in any matter related to an investigation.

Regardless of the fraud referral to PI, the MCO has the discretion to put a Provider suspected of fraud or abuse on pre-payment review or take other preventive actions as necessary to prevent further loss of funds.

The MCO may also be asked to perform its own audit or vet a review conducted by the Department or its designees to determine the scope of any risk. A request of this type must receive immediate attention and forthcoming information should be provided judiciously or as otherwise communicated by the Department or its designee.

Investigations of Members for potential fraud are pursued entirely by the Department in conjunction with, and under specific contractual provisions between the Department and the Office of the South Carolina Attorney General, Medicaid Recipient Fraud Unit (MRFU). Complaints received on Members and determined valid by DRU staff are referred by PI to the MRFU.

SCDHHS Responsibilities

The MCO PI Coordinator will acknowledge receipt of the Provider or Member Fraud Referral Form within five (5) working days by responding to the MCO email indicating a referral was transmitted. PI will work closely with the MCO's compliance and SIU staff to determine as quickly as possible whether a fraud referral to the Office of the South Carolina Attorney General, Medicaid Fraud Control Unit (MFCU) or the Recipient Fraud Unit (MRFU) is warranted.

PI 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 to the MFCU or MRFU;
- 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 and/or additional investigation.

PI will inform the MCO, using the FRAUD Notification Form from SC DHHS PI (the form with red text) on the secure PI website, when PI refers a case of suspected fraud against a Provider to the MFCU. This form gives a date by which the MCO must respond back to PI providing any information regarding a current investigation with the indicated Provider.

PI shall communicate to the MCO all Provider exclusions, terminations for cause and payment suspensions for credible allegations of fraud. These lists are maintained on the secure PI website.

For all cites in Section 11.1.11, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.1.12: Refer to Section 11.1.10, MCO Responsibilities and SCDHHS Responsibilities, of this document.

For all cites in Section 11.1.13 through Section 11.1.14, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.1.15: Refer to Section 11.8, Cooperation and Support in Investigations, Hearings and Disputes, of the Managed Care Contract.

Section 11.1.16: Upon a credible allegation of fraud, PI 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. PI will also immediately inform the MCO when the Provider's fee-for-service payments are suspended due to a credible allegation of fraud. Per regulation 42 CFR 455.23, the MCO(s) must also suspend all Medicaid payments after the Department determines there is a credible allegation of fraud. (Refer to Section 1.1.21, SCDHHS Reporting, and Section 11.1.16 of this document).

A "credible allegation of fraud" is an allegation that has an indication of reliability and may come from any source, including but not limited to the following:

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

PI will determine when a "credible allegation of fraud exists."

Notice of Payment Suspension

PI will notify the MCO to suspend Medicaid payments to a Provider when the agency determines there is a credible allegation of fraud. Payment suspension may involve an individual or an entity. After notification by PI to the MCO of a payment suspension, the MCO must immediately suspend payment to the Provider, but no later than 5 business days, upon notification receipt. Payments may be suspended without first notifying the Provider of the intention to suspend payments. The MCO must generate its own notice of provider payment suspension to the Provider 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:

- The Department 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.

Release of Payments

Once the Department, 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. PI will inform the MCO when a suspended Provider's payments are to be released.

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

The Department or 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 and approved by the Department that would more effectively or quickly protect Medicaid funds.
- The Department determines if the suspension should be removed based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension.
- The Department determines 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 Department determines that payment suspension is not in the best interests of the Medicaid program.

There may be good cause 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 Department determines 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 Department shall 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 Department shall 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.
- Law enforcement declines to certify that a matter is still under investigation.
- The Department determines that payment suspension is not in the best interest of the Medicaid program.

For all cites in Section 11.1.17, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.1.18: An overpayment is discovered on the date of the final written notice of the overpayment determination that the CONTRACTOR sends to the provider, or

An overpayment is discovered on the date on which a provider initially acknowledges a specific overpayment in writing to the CONTRACTOR, or

An overpayment is discovered on the date a State or Federal official or one of their authorized entities first notifies the CONTRACTOR in writing of the overpayment and specifies a dollar amount subject to recovery.

For all cites in Section 11.1.19 through 11.1.20, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.1.21: The Department maintains a secure PI website for the individual MCO to share, upload and download Member and Provider information and data in the context of fraud, waste and abuse reviews, referrals, and Lock-In. The MCO PI Coordinator will assist in establishing a connection and passwords for MCO staff.

- All Provider and Member Fraud Referral Forms are located on the secure PI website and must be transmitted through that site (see the Report Companion Guide for the Provider and Member Fraud and Abuse Referral Forms).
- Any documentation, especially if voluminous or contains PHI, should be uploaded under the MCO's individual Shared Document folder on the secure PI website.
- When requesting MCO staff access to the secure PI website, the MCO Compliance Officer must email the MCO PI Coordinator and provide the MCO staff name, email address, and other requested contact information.
- The Compliance Officer is responsible for maintaining a current list of MCO staff members who have access to the secure PI website. The Compliance Officer is also responsible for notifying the MCO PI Coordinator for the removal of any staff who no longer require access to the secure PI website within twenty-four (24) hours of such knowledge or the next business day whichever comes first.

For all program integrity activities that must be reported, PI will provide the MCO with the report requirements and form and manner, as applicable.

Provider Reviews Monthly Report

The *Provider Reviews Monthly Report* is due by the MCO by the 15th of the following month and uploaded to the appropriate folder within the secure PI website. (For example, January data will be reported on the February 15th report.) If the 15th falls on a state Holiday or weekend, it will be due the following business day.

PI will provide a reporting format with detailed instructions and data definitions (see Report Companion Guide Monthly Fraud for the Abuse Activities Report). This report will include:

- The MCO's open Program Integrity Provider cases, showing Provider name, date opened, status, and the complaint or 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 BEOMB response.
- Providers referred to PI on a Fraud and Abuse Referral Form.
- 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 SIU.
- Overpayment amounts determined.
- Information about the review or audit period and dates the cases were opened or closed, etc.

Provider Collections Quarterly Report

The *Provider Collections Quarterly Report* is due no later than thirty (30) calendar days after the end of each quarter (April 30th; July 30th; October 30th; and January 30th) and uploaded to the appropriate folder within the secure PI website.

The *Provider Collections Quarterly Report* will be based partially on the monthly reports and documents outcomes or results of the MCO's program integrity efforts. This will include the amount of overpayments recovered and whether the MCO applied any sanctions to Providers as a result of program integrity activities. The MCO will be provided with detailed instructions and a reporting format for this information (see the Report Companion Guide for the Quarterly Fraud and Abuse Report).

The MCO shall also report the recovery of any established overpayment on the *Provider Collections Quarterly Report*. Examples of overpayment types include but are not limited to the following:

- Medicaid payments for non-covered services.
- Medicaid payments in excess of the allowable amount for an identified covered service.
- Errors and non-reimbursable expenditures in cost reports.
- Duplicate payments.
- Receipt of Medicaid payment when another payer had the primary responsibility for payment, and is not included in an automated TPL retro recovery process.
- Recoveries due to fraud, waste or abuse.
- Credit balance recoveries.

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

MCO Reporting of Provider Terminations or Denials for Cause

The *Monthly Termination/Denial for Cause Report* is due on the 15th of the following month and must be uploaded to the appropriate folder within the secure PI website. (For example, January data will be reported on the February 15th report.) If the 15th falls on a state Holiday or weekend, it will be due the following business day.

The *Monthly Termination/Denial for Cause Report* documents any Provider termination or denial for cause the MCO imposed during the previous month (see the Report Companion Guide Termination Report and instructions)

When the MCO terminates a Provider for cause or denies a Provider from participating in the MCO's Provider network for cause, the MCO shall report the Provider's termination or denial for cause by:

- Submitting a Fraud and Abuse Referral Form for Managed Care Organizations detailing the cause for which the MCO terminated the Provider or denied the Provider from participating in its Provider network within five (5) business days of the effective date of the MCO's action; (see the Report Companion Guide Fraud and Abuse Referral Form for Managed Care Organizations.)
- Uploading a copy of the Provider's Termination for Cause Letter to the secure PI website.

SCDHHS Reporting of Exclusions, Terminations for Cause and Reinstatements

The Department will notify the MCO when an action was taken to exclude or terminate a Provider for cause, or reinstate a Provider that was either excluded or terminated. PI maintains the Exclusion and Termination for Cause list on the secure PI website. PI also places copies of Provider exclusion and termination for cause notices/letters on the secure PI website.

The MCO shall take immediate action to terminate or exclude any individual or entity that is terminated or excluded by the Department. The MCO will document the actions they take against the Provider on the list on the secure PI website.

Any reinstated Provider must re-apply for enrollment in the state Medicaid program as a participating Provider. Only enrolled Providers can bill the state Medicaid Program for services rendered to Medicaid Program Members. Provider reinstatement means a Provider's eligibility to participate as a servicing Provider in the state Medicaid Program is restored. Reinstatement, however, does not mean the Provider is enrolled in the state Medicaid program.

PI is also responsible for the update to the South Carolina Excluded Provider List published on the SCDHHS website after provider exclusions are completed and any provider appeal is resolved.

SCDHHS Reporting of Suspensions

As a means of notifying the MCO when the Department has taken action to suspend a Provider's payments based on a credible allegation of fraud, PI maintains and updates the Suspension list within the secure PI website. PI will also provide copies of Provider suspension notices/letters within the secure PI website.

Upon notification by PI of a Provider's suspension based on a credible allegation of fraud, either through the list maintained on the secure PI website or the MCO PI Coordinator's email, the MCO will immediately suspend the Provider's Medicaid

payments. The MCO will document the actions they take against the Provider on the Suspension list on the secure PI website.

Refer to Section 11.1.6 and Section 11.9, Suspension of Payment Based on Credible Allegation of Fraud, of this document.

Annual Report

The MCO must provide to PI an *Annual Report of Program Integrity Activities* performed under this contract and will be due at a time as determined by the Department and in the form and manner as determined by PI (see the Report Companion Guide Annual Report).

The *Annual Report of Program Integrity Activities* is a document that contains milestones, activities, goals, objectives and results, and any initiative that the MCO considers a best practice for the previous State Fiscal Year, as well as strategic planning and objectives for the current State Fiscal Year.

Section 11.1.22: The Department administers a Beneficiary Explanation of Medical Benefits (BEOMB) program, as required by 42 CFR 433.116, which gives beneficiaries the opportunity to participate in the detection of fraud and abuse. The Department has created a template letter (see the Report Companion Guide for the BEOMB Letter) that is generated and sent to approximately four hundred randomly selected beneficiaries each month listing all non-confidential services paid during the preceding month. The BEOMBs include Fee-for-Service and Managed Care Services. Beneficiaries are surveyed to verify that they received the services and may be asked additional questions regarding their pharmacy services. A stamped self-addressed envelope is provided for their response.

When a Member in a Managed Care Plan returns a BEOMB with the assertion that some or all the MCO-covered services were not received, the MCO PI Coordinator may upload the BEOMB letter and the BEOMB Referral Form on the secure PI website (see the Report Companion Guide for the BEOMB Referral Form). The PI Coordinator may email the appropriate MCO notifying them of the transmittal. The MCO must conduct a preliminary investigation to determine whether the services were received. If the MCO substantiates the allegations, they will forward the BEOMB to PI using the Fraud and Abuse Referral Form for Managed Care Organizations (see the Report Companion Guide for the Fraud and Abuse Referral Form).

PI may conduct a special targeted BEOMB job where Members are surveyed to verify whether services from a Provider under PI review were received. PI shall retain any BEOMB's responses as part of its review regardless of the payment delivery system.

The MCO is also responsible for conducting an independent BEOMB process. When a Member returns a BEOMB to the MCO with the assertion that some or all the MCO's covered services were not received, the MCO must conduct a preliminary investigation

to determine whether the services were provided as reported in the encounter. If the MCO substantiates the allegation, it will forward the BEOMB to PI, using the Fraud and Abuse Referral Form for Managed Care Organizations (see the Report Companion Guide for the Fraud and Abuse Referral Form).

The Department's "Confidential Services" are defined as those sensitive services which the disclosure will violate a beneficiary's right to privacy. The services below are excluded from monthly BEOMB statements mailed to beneficiaries for their verification of Medicaid services received.

- Payment category = 10 (MAO Nursing Home)
- Procedure code modifier = 0FP (Services Part of Family Planning Program)
- Provider type = 04 (Private Mental Health), 10 (Mental Health and Rehab), 00 (Nursing Home), and 70 (Pharmacy)
- Category of service = 13 (ICF Mental Retardation)
- MMIS provider control facility code (type ownership) = 011 (DDSN)
- MMIS provider control facility code = '010' (Dept Mental Health) and Provider Number <> '136078'
- Confidential Diagnosis Codes as determined by the Confidential Indicator set by the MMIS Diagnosis Reference File. (The Diagnosis Code List will be maintained on the secure PI website.)

Section 11.1.23: Refer to Section 11.10, Statewide Pharmacy Lock-In Program (SPLIP), of this document.

For all cites in Section 11.1.24, please refer to the contract for all requirements between MCO and SCDHHS.

11.2 Compliance Plan Requirements

For all cites in Section 11.2.1 through Section 11.2.12, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.2.12.1: The MCO will establish written policies and procedures adopting routine checks of federal and state databases to confirm the identity and determine the exclusion status of any Provider and/or Subcontractor, and any person with an ownership or control interest, or an agent, or managing employee of the Provider and/or Subcontractor. This includes checking the Social Security Administration's Death Master File, the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM) Exclusions Database, and any other databases the Department or the Secretary of Health and Human Services may prescribe (e.g., the South Carolina List of Excluded Providers and the South Carolina List of Providers Terminated for Cause). MCO written procedures shall include requirements that the MCO shall check

federal and state provider exclusion and termination for cause databases upon contracting or credentialing the provider and no less than monthly thereafter.

When an MCO determines that a Provider/Subcontractor, or a Provider's/Subcontractor's owner, agent, or managing employee, or an owner, agent, or managing employee of the MCO entity is excluded and/or terminated for cause from Medicare and/or Medicaid, the MCO shall immediately terminate the prohibited relationship. The MCO will then submit to PI any documentation of the determination and all actions taken as a result of the relationship. The MCO must identify and recoup any erroneous Medicaid payments. The MCO must report this Provider to PI on the Fraud and Abuse Referral Form and report this as a case on their Monthly Report (see the Report Companion Guide for the Fraud and Abuse Referral Form).

The MCO may retain a relationship with a Provider/Subcontractor after the MCO determines the Provider's/Subcontractor's owner, agent, or managing employee is excluded or terminated from Medicare and/or Medicaid for cause only after the Provider/Subcontractor terminates the prohibited relationship and any erroneous Medicaid payments made to the excluded/terminated individual or entity are reimbursed to the state Medicaid program.

The MCO shall maintain documentation for audit purposes that show the MCO conducts routine checks of federal and state databases to identify individuals and/or entities that are excluded or terminated from Medicare or Medicaid for cause.

Section 11.2.13.1: The Department will provide the form and manner on which the Compliance Plan must be submitted by the MCO. (See the Report Companion Guide, 2016 Compliance Plan Matrix)

11.3 CONTRACTOR's Controls

For all cites in Section 11.3, please refer to the contract for all requirements between MCO and SCDHHS.

11.4 Reviews, Investigations and Audits

For all cites in Section 11.4 through Section 11.4.1, please refer to the contract for all requirements between MCO and SCDHHS.

Unless otherwise specified below, refer to Section 11.5 of the Contract for all requirements between MCO and SCDHHS.

Section 11.4.2: The MCO may utilize a three year look back period from the last adjudication date of the claim for conducting post payment reviews and audits for FWA activities. For any review or audit periods that exceed the three year period, the Compliance Officer must send a written request to the MCO PI Coordinator requesting

permission from the Department, and specifying the dates and details of the review or audit.

For any desk review the MCO shall send a letter, certified mail with return receipt signature service through the US Postal Service, to the provider requesting medical records. If the Provider fails to provide records, the MCO must conduct an onsite review. Failure to provide requested medical records in accordance with the above may be cause for termination. Refer to Section 1 – “General Information and Administration -- Records / Documentation Requirements” of the provider manual.

MCO requests to terminate should be submitted to Medicaid Program Integrity via the Fraud and Abuse Referral Form for Managed Care Organizations (see the Report Companion Guide for the Fraud and Abuse Referral Form). The request should consist of documentation to include, but not limited to:

- The certified letter(s) mailed to the provider, along with the return receipt documentation.
- The onsite report detailing the investigative actions associated with the onsite investigation.
- Any other documentation to support the request to terminate.

Section 11.4.3: At any time during a review conducted by PI, PI may refer the review to the MCO to conclude the MCO portion of the review. Any case that PI refers to the MCO should be recorded on its Monthly Report (see the Report Companion Guide Quarterly Report).

For all cites in Section 11.4.3.1 through Section 11.4.3.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.4.3.3: PI, or its designees, may review services billed using the Department’s encounter data.

Section 11.4.3.4: The MCO will have up to thirty (30) calendar days from the date of its receipt to vet the review and/or investigative outcomes (herein referred to as a draft report) performed by the Department or its designees and return with its comments to the entity which performed the review. However, where the threat of harm to the Medicaid Program is considered significant by PI, the MCO must prioritize the vetting process and return the review with comments to the requesting entity as soon as reasonably possible, but not greater than thirty (30) calendar days from receipt of the request by the MCO.

The MCO must validate the findings, and as necessary communicate any recommendations for changes to the entity performing the review and also the MCO PI Coordinator.

Section 11.4.4: Upon finalization of the draft report (herein referred to as the final report) by the entity performing the review, the MCO will receive a final report and may also receive a directive by the reviewing entity to initiate recoupment from the provider. In accordance with Section 11.5.4 of the Contract, if the MCO receives such a request, the MCO will initiate action to recoup all improper payments within thirty (30) calendar days of notification.

If a Provider requests reconsideration or files an appeal, the MCO must respond in accordance with the MCO's current policies and procedures. Furthermore the MCO must initiate action within thirty (30) calendar days to recover the overpayment from the Provider once the time frame for timely filing of the reconsideration has occurred, or if the applicable proceedings have run their course, whichever occurs later.

Upon determination that the MCO is unable to recover an overpayment from the Provider, the reason must be communicated to the MCO PI Coordinator in writing.

Section 11.4.5: In the event of an established Provider Overpayment or underpayment, the CONTRACTOR shall adjust, void or replace, as appropriate, each encounter claim to reflect the proper claim adjudication. If a settlement agreement is reached, those overpayments may be reported outside the claims processing system in accordance with 11.7.1.2. All overpayments identified, and collections made must be reported by the MCO PI on its Quarterly Fraud and Abuse report.

For reviews originated by the MCO, if the MCO identifies conduct that it reasonably believes constitutes a violation of State or Federal law concerning Medicaid fraud, then a fraud referral must be submitted to PI. Unless directed otherwise by PI and/or a law enforcement entity, the MCO may continue its review after ten (10) business days of receipt by PI. In cases where a referral has been made, the MCO is not permitted to provide the review or investigative results or take any actions based on the review findings without clearance from PI. Additionally, the MCO is not permitted to disclose to the provider at any time during the course of the review that there is a suspicion of fraud or that a referral has been made.

The Department and the MCO shall engage in meaningful collaboration efforts to establish effective, expedited, and secure exchange of data and information pertinent to reviews conducted by the MCO or the Department.

For any review of suspected Provider fraud that is referred from the MCO to PI and does NOT result in a fraud referral to the MFCU, PI may either return responsibility of the review to the MCO or retain the review for further development.

For all cites in Section 11.4.6, please refer to the contract for all requirements between MCO and SCDHHS.

11.5 Referral Coordination and Cooperation

For all cites in Section 11.5.1 through Section 11.5.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.5.3.1: The MCO's Compliance Officer and Program Integrity Coordinator shall meet at least quarterly with PI/SURS staff and MCO PI Coordinator. In addition, the MCO's Compliance Officer, Program Integrity Coordinator, and MCO program integrity staff should meet or confer with DHHS PI staff as often as needed on joint cases and Fraud and Abuse referrals.

For all cites in Section 11.5.3.2 through Section 11.5.4, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.5.5: Refer to Section 11.1.21, Annual Report, of this document.

11.6 Overpayments, Recoveries, and Refunds

For all cites in Section 11.6.1 through Section 11.6.1.1 please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.6.1.2: The MCO will report recoveries of overpayments as a case on the Monthly Report.

For all cites in Section 11.6.2 through Section 11.6.2.1.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.6.2.2.2: The MCO shall remit to the Department with notification to the MCO PI Coordinator those funds offset as a result of this provision within thirty (30) calendar days of such offset. Such notice shall include the following information as applicable: Provider Name, NPI, CCN, Date of Service, Refund /Adjustment Date; Refund Reason, PI Case Number, MCO Reference Number, Check Number, Check Date, and Offset was requested by PI.

For all cites in Section 11.6.2.2.2 through Section 11.6.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.6.3.1: Such recoveries shall include those outlined in Section 11.6.3.1.2.1. Payments made to a Provider that were otherwise excluded from participation in the Medicaid program, and subsequently recovered from that Provider by the MCO.

Section 11.6.3.1.1: Refer to Section 11.1.10.

For all cites in Section 11.6.3.1.2 through Section 11.6.3.1.2.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.6.3.1.2.2: The MCO may collect from a Provider as a result of its investigation due to FWA. However, if the MCO investigation resulted in a Fraud Referral to PI, the MCO must obtain written authorization from PI prior to the initiation of any recovery due to fraud or potential fraud.

For all cites in Section 11.6.4, please refer to the contract for all requirements between MCO and SCDHHS

11.7 Cooperation and Support in Investigations, Hearings, and Disputes

For all citations in Section 11.7, please refer to the contract for all requirements between MCO and SCDHHS.

11.8 Suspension of Payment Based on Credible Allegation of Fraud

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

Refer to Section 11.1.16 and 11.1.21 of this document for suspensions and reporting of suspensions. Upon notification by PI to the MCO of a suspension of payment based on a credible allegation of fraud pursuant to 42 CFR §455.23, the MCO must also suspend payments to any Provider(s) and/or administrative entity(s) involved.

11.9 Statewide Pharmacy Lock-in Program (SPLIP)

In accordance with 42 CFR § 431.54 (e), the Department will identify Members through SURs reporting who are using Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the Department. PI will restrict identified Members to a two year period in which they will obtain all Medicaid pharmacy services from one designated Provider.

In order for the Department to impose these restrictions per the CFR, the following conditions must be met:

- The Member must be given notice and opportunity for a fair hearing before imposing the restriction.
- The Member must have reasonable access (taking into account geographic location and reasonable travel) to Medicaid services of adequate quality.
- The restrictions do not apply to emergency services furnished to the Member.

Enrollment in the Department's Statewide Pharmacy Lock-In Program (SPLIP) will not result in the denial, suspension, termination, reduction or delay of medical assistance to any Member. A Medicaid Member who has been notified in writing by the Department of a pending restriction due to misutilization of Medicaid services may exercise his/her right to a fair hearing, conducted pursuant to R126-150 et. Seq.

Section 11.9.1: PI will generate a quarterly report that will review all Medicaid Member's claims for a designated six (6) month period. The report will look at twenty (20) different weighted criteria as establish by the Department and the MCOs based on research; with the majority of them analyzing the use of pain medications. The report will automatically assign a Member a designated lock in pharmacy based on the pharmacies they most utilized during the six (6) month period. The twenty (20) criteria are as follows:

FFS and Encounter claims included

Pharmacy Dispensed Dates: XX/XX/20XX - XX/XX/20XX (6 months)

Voids Removed

Excluded members in Hospice, with a date of death or no longer Medicaid eligible

Excluded members currently in the lock-in program

Only included members with a Score > 0

Excluded members Age <= 16 and (Aid Category = 57 (TEFRA) or RSP in list below)

RSP4_CODE	RSP_DESC
AUTW	Autism Waiver
CHPC	CLTC Childrens PCA
DMRE	DMR Waiver/Established
DMRN	DMR Waiver/New
MCFC	Medically Fragile Children Pgm
MCNF	Med Fragile Non-Foster Care
WMCC	Medically Complex Children

Composite Score Measures

Score

1. CII Without Prof Claim in Previous Six (6) Mo

(1)

Identifies any member with a DEA Schedule II prescription without a professional claim in the previous six (6) months. The professional claims look back was not limited to the time period of this report.

2. Fifteen or More RX in Thirty (30) Days

(0.5)

Identifies members with five (5) or more prescriptions (any schedule) within a thirty day (30) period. This measure is based on a rolling thirty (30) days within the six (6) month time period of this report.

Composite Score Measures	Score
<p>3. Five or More Controls in Thirty (30) Days</p> <p>Identifies members with five (5) or more DEA Schedule II-V prescriptions within a thirty-day period. This measure is based on a rolling thirty (30) days within the six (6) month time period of this report.</p>	(3)
<p>4. Two or More ER Visits In Thirty (30) Days and Controlled RX</p> <p>Identifies members with two (2) or more non-emergent ER visits within a thirty-day period and a DEA Schedule II-V prescription within the same thirty (30) days. This measure is based on a rolling thirty (30) days within the six (6) month time period of this report.</p> <p>fac_revenue_cd = '0450','0451' OUTPAT_SERVICE_LEVEL = '1' OUTPAT_SERVICE_LEVEL was tagged to encounter claims from Diagnosis record based on primary diagnosis code.</p>	(1)
<p>5. GT 3600 mg Oxycodone HCL in Thirty (30) Days</p> <p>Identifies members with more than 3600 mg of Oxycodone HCL (generic name for Oxycontin) in a thirty-day period. This measure is based on a rolling thirty (30) days within the six (6) month time period of this report.</p> <p>Total mg per prescription = strength * quantity dispensed</p>	(1)
<p>6. Two or More Out of State Pharmacies for Controls</p> <p>Identifies members with DEA Schedule II-V prescriptions from two (2) or more out of state pharmacies.</p>	(2)
<p>7. Two Controls From Two (2) Pharmacies within Two (2) Days</p> <p>Identifies members with two (2) or more DEA Schedule II-V prescriptions dispensed by two (2) different pharmacies on two (2) consecutive days.</p>	(1)
<p>8. Suboxone within Six (6) Months</p> <p>Identifies members with Suboxone prescriptions during the time period of this report.</p> <p>generic_name = 'Buprenorphine Hydrochloride/Naloxone Hydrochloride'</p>	(1)
<p>9. Opioid Within Thirty (30) Days After Suboxone</p> <p>Identifies members with an opioid prescription within thirty (30) days after a Suboxone prescription.</p> <p>Suboxone: generic_name = 'Buprenorphine Hydrochloride/Naloxone Hydrochloride') Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII'</p>	(10)

Composite Score Measures	Score
<p>10. Ten or More Pills Per Day For Controlled RX</p> <p>Identifies members with DEA Schedule II-V prescriptions allowing for ten (10) or more pills per day.</p> <p>Master Form = Capsule or Tablet</p> <p>Qty_Dispensed / Days_Supply >= 10</p>	(2)
<p>11. Pill Count for Controls GT 600</p> <p>Identifies members with a pill count exceeding 600 for all DEA Schedule II-V prescriptions dispensed during the six (6) month time period of this report.</p> <p>Master Form = Capsule or Tablet</p>	(2)
<p>12. Hist of Drug Dependence with Benzo or Opiate RX</p> <p>Identifies members with a drug dependence diagnosis code and a Benzodiazapine or Opiate prescription during the six (6) month time period of this report.</p> <p>Diagnosis code like '304*' - checked all diagnosis codes on professional and hospital claims</p> <p>Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII'</p> <p>Benzodiazepines: Redbook_int_ther_class like '*BENZODIAZEPINES*' and Redbook_dea_class_cd = 'CIV'</p>	(1)
<p>13. Hist of Poison Overdose with Benzo or Opiate RX</p> <p>Identifies members with a poisoning/overdose diagnosis code and a Benzodiazapine or Opiate prescription during the six (6) month time period of this report.</p> <p>Diagnosis code = '960' to '9799' - checked all diagnosis codes on professional and hospital claims</p> <p>Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII'</p> <p>Benzodiazepines: Redbook_int_ther_class like '*BENZODIAZEPINES*' and Redbook_dea_class_cd = 'CIV'</p>	(1)
<p>14. Five or More Prescribers</p> <p>Identifies members with five or more prescribers during the six (6) month time period of this report. All prescriptions included.</p>	(0.5)

Composite Score Measures	Score
<p>15. Two or More Opioid Prescribers</p> <p>Identifies members with two or more prescribers issuing an opioid prescription during the six (6) month time period of this report.</p> <p>Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII'</p>	(1)
<p>16. Three or More Prescribers for Controlled Substance</p> <p>Identifies members with three (3) or more prescribers issuing a controlled substance (DEA Schedule II-V) during the six (6) month time period of this report.</p>	(1)
<p>17. Four or More Pharmacies</p> <p>Identifies members with drugs dispensed by four (4) or more pharmacies during the six (6) month time period of this report. All prescriptions included.</p>	(0.5)
<p>18. Two or More Pharmacies for Controlled Substance</p> <p>Identifies members with controlled substances (DEA Schedule II-V) dispensed by two or more pharmacies during the six (6) month time period of this report.</p>	(1)
<p>19. Three or More Cntrl Subst and Drugs of Concern</p> <p>Identifies member with three (3) or more drugs between controlled substances (DEA Schedule II-V) and other drugs of concern.</p> <p>Other drugs of concern include tramadol, cyclobenzaprine, methocarbamol, tizanidine and metaxalone.</p> <p>Unique count of generic_name > 3</p>	(1)
<p>20. On Cocktail Reports</p> <p>Identifies members also found on the "Holy Trinity" or "The Cocktail" reports for the same six (6) month time period. These reports identify members who were dispensed all components of a known drug cocktail during a thirty-day period.</p>	(3)

The report will assign a score and rank Members selected for enrollment in the Lock-In Program (SPLIP). The Department can revise these criteria as needed; for example to include current drugs being sought by abusers according to national trends.

The secure PI website houses a live Member databank that must be maintained by the MCO on a daily basis over the course of the Member's lock in period. PI will upload the selected Members on the secure PI website each quarter and will notify the MCO by

email when this has been completed. The email will include the total number of selected Members uploaded and the six (6) month review claim period. The MCO must record all of the Member's activities on the secure PI website.

All Members selected by the Department as candidates, and uploaded on the secure PI website for the MCO by the Department, must be placed in the MCO's Lock-In Program. The MCO shall conduct a second review to identify selected Members on a case by case basis that would not benefit from the program due to complex drug therapy or other case management needs. Only those members identified during this review may be exempted from enrollment in the Lock-In program. The MCO must document on the secure PI website the reason a particular Member was not locked in.

The MCO may lock in additional Members based on the MCO's own criteria. These additional Members will be added on the secure PI website by the MCO (or the MCO may ask for assistance from PI if it is a large upload). For these additional Members, the MCO will assign its Plan name in the "Selected By" field to indicate the member was chosen by the MCO and not the Department.

Section 11.9.2: After the Pharmacy review, and no later than thirty (30) days prior to the "Effective Date" of enrollment, the Member must be sent the Member Initial Notification Letter by Certified mail to include:

- The Member name and Medicaid ID
- The six (6) month review period
- The "Effective Start" and "Termination Date"
- The pre-selected designated pharmacy
- Directions for changing the designated pharmacy to one of their choice
- Program Instructions
- Appeal Rights and directions on how to file the Appeal

If the Member opts to choose a different pharmacy as his or her sole Provider, he or she is given twenty (20) days from the date of the Certified Initial Member Notification Letter to call and request a pharmacy of his or her choice. After the Effective Date, all changes will require a request and approval.

Per the Initial Member Notification Letter, the Member also has the right to request a detailed claims report for the six (6) months of claims data that ranked them for enrollment in the SPLIP. Because PI generates the report that identifies the six (6) months of claims in question, and which may cross MCO or FFS periods, the MCO must request this report from PI.

Section 11.9.2.2: The Member must be locked into a designated pharmacy no later than ninety (90) days after the initial quarterly referral from the Department, unless the Member files an appeal. The established timeline below is recommended.

Lock-in Schedule

March 1 – Run Report based on Pharmacy Dispensed Date 07/1/2020 to 12/31/2020

(Request to run can be made during the last two [2] weeks.)

March 1 to March 30 – Thirty (30) days for the Pharmacy Dept. to complete the Clinical Component

April 1 to April 30 – Thirty (30) days for PI LI to complete data entry in MMIS and prepare for mailing

May 1 – Notification Letter to Beneficiaries (twenty [20] days to respond)

May 20 – Letter to selected Pharmacy (ten [10] days to respond)

June 1 - Effective Lock-In Date

June 1 - Run Report based on Pharmacy Dispensed Date 10/1/2020 to 3/31/2021

(Request to run can be made during the last two [2] weeks in May)

June 1 to June 30 - Thirty (30) days for the Pharmacy Dept. to complete the Clinical Component

July 1 to July 31 - Thirty (30) days for PI LI to complete data entry in MMIS and prepare for mailing

August 1 - Notification Letter to Beneficiaries (twenty [20] days to respond)

August 20 - Letter to selected Pharmacy (ten [10] days to respond)

September 1 - Effective Lock-In Date

September 1 - Run Report based on Pharmacy Dispensed Date 1/1/2021 to 6/30/2021

(Request to run can be made during the last two [2] weeks in August.)

September 1 to September 30 - Thirty (30) days for the Pharmacy Dept. to complete the Clinical Component

October 1 to October 30 - Thirty (30) days for PI LI to complete data entry in MMIS and prepare for mailing

November 1 - Notification Letter to Beneficiaries (twenty [20] days to respond)

November 20 - Letter to selected Pharmacy (ten [10] days to respond)

December 1 - Effective Lock-In Date

- December 1** - Run Report based on Pharmacy Dispensed Date 4/1/2021 to 9/30/2021
(Request to run can be made during the last two [2] weeks in November)
- December 1 to December 31 - Thirty (30) days for the Pharmacy Dept. to complete the Clinical Component
- January 1 to January 31 - Thirty (30) days for PI LI to complete data entry in MMIS and prepare for mailing
- February 1 - Notification Letter to Beneficiaries (twenty [20] days to respond)
- February 20 - Letter to selected Pharmacy (ten [10] days to respond)
- March 1 - Effective Lock-In Date

Section 11.9.3: The Member will be restricted to, or locked into, one (1) pharmacy where all of his or her Medicaid paid prescriptions will be filled for a period of twenty (24) consecutive months (two [2] years). The assigned two year continuous period is provided to the Member in the Member Initial Notification Letter as “Effective Date” to “Termination Date”. Regardless of the Member’s movement between MCOs, or in and out of Medicaid eligibility, his or her enrollment in the SPLIP will continue until the “Termination Date” as provided in the Member Initial Notification Letter.

There are times during a Member’s lock in period that a second pharmacy may be warranted. These requests must be evaluated and granted on a case by case basis, and must be initiated by the Member, or his or her doctor, pharmacist, or immediate care giver. Some examples would include, but not be limited to: needing a specialty drug, compound, or IV infusion therapy; people who travel from small towns to a medical center in a major city; being allergic to certain generics stocked at the Lock-In pharmacy; and going out of state for treatment with an extended recovery time, etc. In these cases, the Member will be assigned a second lock in pharmacy and this pharmacy will be noted in the case file located on the secure PI website.

PI staff will review SPLIP Member’s eligibility monthly and update the data on the secure PI website for each MCO. If a Member changes enrollment between MCOs or FFS, PI will update that data on the secure PI website indicating the new Provider of services. The Member’s status will then be changed to pending (P) and a YES will be placed in the transfer column. The Member’s record will then be transferred to the new Provider and the Member’s lock-in period will be continued.

TRANSFERS:

A transfer occurs when a Member enrolling in an MCO (receiving MCO) was previously enrolled under FFS or a different MCO provider. It is the responsibility of the receiving MCO to continue the Member’s enrollment in the SPLIP. PI initiates this transfer through the live databank on the secure PI website, which includes dates, current pharmacy and notes.

The following pertain to transfers and documenting the Member record on the secure PI website:

- Do **NOT** delete or overwrite the dates in the “Dt CertLtr Sent to Member” column.
This represents the Date the Member was mailed the initial SPLIP enrollment notification letter by someone other than the receiving MCO. This date WILL NOT change.
- Do **NOT** delete or overwrite the dates in the “UNIVERSAL 2 Yr Eff Start Dt” and “UNIVERSAL 2 Yr End Dt” columns.
This is the two (2) year time period assigned to the Member. Once the Member has been enrolled in the program, this term WILL NOT change, regardless of transfers between MCOs or in and out of Medicaid eligibility.
- The receiving MCO CANNOT add additional months to the Universal 2 year time period.
- If the receiving MCO chooses to send a letter to the transferred Member advising them of his or her continued enrollment in the LI program, the “UNIVERSAL 2 Yr End Dt” will remain the same as given the Member in their initial enrollment notification letter.
The receiving MCO WILL NOT RESTART the Universal 2 year period when it receives the transferred Member.
- The receiving MCO MUST enter the date it received and entered the transferred Member in the “Transfer Completed” column.
- Place the Member in lock-in status as soon as possible and continue with the effective dates and the selected pharmacy indicated in the transferred record.
 - The Member is not given the option to change his or her selected pharmacy of record. However, as a newly enrolled Member in the receiving MCO, the Member may select a new pharmacy.
 - The receiving MCO will document this pharmacy change in the Member’s record.

Medication Overrides:

Reasons for overrides and changes/additions include, but are not limited to: medication needed (strength, quantity, brand, and/or type not in stock), the Member is out of town, the selected pharmacy went out of business, or the selected pharmacy chooses not to serve the Member for cause.

It is the responsibility of the Member, and his or her pharmacist or doctor, to select a new pharmacy that can accommodate the Member’s needs.

Pharmacy Changes/Additions:

When a Member is granted a pharmacy change, the Member’s record on the secure PI website must reflect the change. It is important to add the new pharmacy and terminate

the old one, and to update the pharmacy information, date for last pharmacy change, and reason why there was a pharmacy change.

An override or emergency:

- Is allowed after regular business hours, weekends, or holidays. The Member will only be given a three (3) day (seventy-two (72) hour) supply of the medication.
- If the Lock-In Pharmacy verifies that the medication is not in stock, a coordinating pharmacy of the Member's choice that can supply the medication, will be approved and granted an override of up to a thirty (30) day supply of that specific medication.

If a Member moves, he or she can request a change of Lock-In pharmacy to one more conveniently located. Other reasons for a change of pharmacy may be considered.

Point of Sale:

The Point of Sale system will notify any pharmacy that is not the lock-in Provider of the Member's pharmacy restriction at the time of claim submission and will deny the claim. On rare occasions, for example, due to a change in the seriousness of a Member's health or due to a major medical emergency, the MCO always has the option of removing the Member from the SPLIP if it is in the best interest of the Member's health. These will be on a case by case basis and should be granted by the Pharmacy Director. All notes pertaining to this removal must be documented in the Member's record on the secure PI website.

Section 11.9.4: The Member has a right to file an appeal within thirty (30) days from the receipt of the Certified Initial Member Notification Letter if they believe the claims Medicaid paid in the six (6) month review period contain an error. (Refer to the Contract, Section 8 Appeals). If the Member is enrolled in an MCO, he or she must first appeal to the MCO. If this appeal does not end in favor of the Member, a second appeal to the Department may be requested. The MCO must keep appeal records for audit purposes.

If the Member files an appeal, a "stay of action" will be granted and removed from immediate placement into the SPLIP. It is recommended that prior to the hearing date, contact be made with the Member in an attempt to resolve the issue; for example, selecting a new pharmacy, assigning a second pharmacy, or removal from the program.

- If the Member wins the first appeal to the MCO, he or she is removed from placement into the SPLIP and the reason is documented on the secure PI website. If the Member is identified as a SPLIP candidate in future criteria selections, the outcome of this appeal will be taken into consideration.
- If the Member loses the first appeal to the MCO, the MCO must await the Hearing Officers Official Hearing Notification Outcome. The stay of action will remain for the Member's enrollment in the program. The MCO will review case status on the date by which a second appeal must have been filed as established by the Hearing Officer.

1. If the Member files a second level appeal to the Department, the stay of action remains until the Department's Hearing Officer renders his Official Hearing Notification Outcome.
 - If the Member wins the second level appeal to the Department, he or she is removed from placement into the SPLIP and the reason is documented on the secure PI website. If the Member is identified as a SPLIP candidate in future criteria selections, the outcome of this appeal will be taken into consideration.
 - If the Member loses the second level appeal to the Department, the Member can either be placed in the SPLIP the following month or with the next Quarterly group. The Member will be given an updated Initial Member Notification Letter WITHOUT appeal rights.
2. If the Member does not file a second level appeal to the Department and the time to file has expired, the Member can either be placed in the SPLIP the following month or with the next Quarterly group. The Member will be given an updated Initial Member Notification Letter WITHOUT appeal rights.

The MCO must document all appeal information in the Member's case file located on the secure PI website.

Section 11.9.5: Prior to the Termination Date, the Member will be notified by letter of his or her removal from the program. After removal from the program, the Member's future prescription claims will be monitored. If the 20 criteria report identifies the Member based on his or her score, they will automatically be re-enrolled in the SPLIP.

11.10 Ownership and Control

Section 11.10: 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 Provider Policy and Procedure Guide, and 42 CFR §§ 455.104, 455.105 and 455.106 (2009, as amended). Such information shall be disclosed on the 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 the Department, 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.

The MCO is required to utilize the data fields contained in the new version of the Ownership Disclosure Form (Form 1514) for all benefit/direct service Providers. MCOs may add additional data fields beyond those currently on the Ownership Disclosure Form (Form 1514) that are necessary to identify and contact the provider. The MCO is required to have all non-benefit/non-direct service subcontractors submit an ownership disclosure form (this form may or may not be the same Form 1514 form utilized for benefit/direct service providers) prior to execution of the contract (agreement). Additionally, the MCO 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 MCO's files. After verification by the MCO, if it is discovered the subcontractor/staff/owners/board members, or any of their subcontractors/staff/owners/board members are on the Excluded Provider List, the MCO must immediately report the information to the Department and terminate the contract.

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

For all cites in Section 11.11.1 through Section 11.11.5, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.11.6: Termination for cause reasons shall be consistent with the termination for cause rationale listed in the CMS CPI-CMCS Informational Bulletin dated January 20, 2012, SUBJECT: Affordable Care Act Program Integrity Provisions – Guidance to States – Section 6501 – Termination of Provider Participation under Medicaid if Terminated under Medicare or other State Plan.

Section 11.11.7: When PI takes action to exclude or to terminate a Provider for cause, or to reinstate a Medicaid Provider's billing privileges, the Provider is informed of these actions through a letter sent via certified mail. "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. The MCO cannot contract with Providers that have been debarred, excluded, or terminated from Medicare and/or Medicaid for cause. The Department updates its website as needed with names of excluded individuals and entities.

PI provides copies of Provider exclusion and termination for cause notices to the MCO on the secure PI website. (See Section 11.1.21, SCDHHS Reporting of Exclusions, Terminations for Cause and Reinstatements, of this document) The MCO is also required to complete routine checks of LEIE, SAM and the SC Excluded Provider List to determine if Providers, Subcontractors, owners, agents, or managing employees are excluded from participating in Medicare and/or Medicaid.

When PI reinstates an excluded Provider's eligibility to participate in the state Medicaid program, it removes the Provider's name from the SC Excluded Provider's List located on the SCDHHS website. PI notifies the Provider in writing via certified mail. PI notifies the MCO of the Provider's reinstatement on the secure PI website and uploads a copy of the Provider's Reinstatement Notice. Reinstatement is not enrollment in the state Medicaid program. To participate in the Medicaid program, the Provider must submit an enrollment application as specified in the Provider Enrollment Manual found at <https://www.scdhhs.gov/Provider>.

"Termination" means the Department has taken an action to revoke a Provider's Medicaid billing privileges, the Provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of the Provider or the Department that the revocation is temporary. Provider termination for cause is based on the Departments Provider enrollment policies found in the Provider Enrollment Manual at <https://www.scdhhs.gov/provider-type/provider-enrollment-manual>. There are multiple reasons why the Department can terminate a Provider for cause.

The MCO shall report all Provider terminations for cause to PI using the Fraud Referral Form for Providers located on the secure PI website and on the Monthly Termination Denial for Cause Report (see the Report Companion Guide Fraud and Abuse Referral Form and the Termination).

The Division of Program Integrity/SURS determines if a Provider meets the conditions for termination for cause and ensures all Providers terminated for cause from the state Medicaid program are reported to the Centers for Medicare and Medicaid Services (CMS) and to the DHHS Office of the Inspector General (OIG).

Section 11.11.8: Refer to Section 11.1.21, MCO Reporting of Provider Terminations or Denials for Cause, of this document.

Section 11.11.9: Refer to Section 11.1.21, MCO Reporting of Provider Terminations or Denials for Cause, of this document.

Section 11.11.10: In the event the MCO is audited by CMS, its agents, or its designees, or by the Department, its agents, or its designees, the MCO must maintain attestations and search results to demonstrate performance of Provider and Subcontractor screenings and to determine the exclusion status, termination for cause status, or debarment from participation in Medicare, Medicaid, the State Children's Health Insurance Program, and/or all federal health care programs, against the screening mechanisms in Section in 11.11.11.1 through Section 11.11.11.4.

For all cites in Section 11.11.11, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.11.11: The CONTRACTOR must screen all providers and subcontractors against the List of Excluded Individuals and Entities (LEIE) website,

Section 11.11.11.2: The CONTRACTOR must screen all providers and subcontractors against the “System for Award Management” (formerly the Excluded Parties List Service) administered by the General Services Administration.

Section 11.11.11.3: The CONTRACTOR must screen all providers and subcontractors against the Department’s published list of Providers excluded from participation in the Medicaid program, available on the Department’s website; and

Section 11.11.11.4: The CONTRACTOR must screen all providers and subcontractors against the Department’s internal list of terminated or suspended Providers in the Medicaid program, available on the shared secure PI website.

For all cites in Section 11.11.11.5 through Section 11.11.6, please refer to the contract for all requirements between MCO and SCDHHS.

11.12 Prohibited Affiliations with Individuals Debarred by Federal Agencies

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

11.13 Provider Termination / Denial of Credentials

For all cites in Section 11.13 through Section 11.13.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 11.13.3: The MCO shall terminate any Provider in accordance with federal regulations found at 42 CFR §455.416 *Termination or denial of enrollment*, and SCDHHS policies.

11.14 Information Related to Business Transactions

For all cites in Section 11.14, please refer to the contract for all requirements between MCO and SCDHHS.

11.15 Information on Persons Convicted of Crimes

For all cites in Section 11.15, please refer to the Contract for all requirements between MCO and SCDHHS.

12.0 Marketing Program

12.1 General Marketing Requirements

Marketing, as defined by 42 CFR 438.104, means any communication, from an MCO to a Medicaid beneficiary who is not enrolled in that entity that can reasonably be

interpreted as intended to influence the beneficiary to enroll in that particular MCO's Medicaid product, or either to not enroll in or to disenroll from another MCO's Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan.

12.2 Guidelines for Marketing Materials and Activities

The MCO shall be responsible for developing and implementing written Marketing plans for all proposed Marketing activities. The Marketing plan shall include details identifying the target audiences, marketing strategies to be implemented, marketing budget, and expected results.

Marketing materials, as defined by 42 CFR 438.104, means materials that are produced in any medium, by or on behalf of an MCO and can reasonably be interpreted as intended to market the MCO entity to potential enrollees.

All Marketing Materials must contain the South Carolina Healthy Connections logo and the SC Healthy Connections Choices toll-free number. The MCO and Healthy Connections logos and associated phone numbers must be proportional in size and location. The Marketing plan and all related accompanying materials are governed by 42 CFR § 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. The MCO shall ensure that all written Marketing materials are written at a grade level no higher than the sixth (6th) grade (6.9 on the reading scale) or as determined appropriate by SCDHHS.

MCOs are required to make available written information in each prevalent non-English language. 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%). 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.

Marketing Materials 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

12.3 Marketing Plan Requirements

For all cites in Section 12.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 12.3.2 through Section 12.3.4: All SCDHHS Marketing 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 thirty (30) calendar days in writing to the SCDHHS' Appeals Department.

The MCO's Marketing 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" with a fair market value of no more than \$10.00; with such gifts being offered regardless of the Beneficiary's intent to enroll in a plan. "Give-a-away items" may not be for alcohol, tobacco, or fire arms. Cash gifts of any amount, including contributions made on behalf of people attending a Marketing event, gift certificates or gift cards are not permitted to be given to Beneficiaries or the general public. "Give-a-way items" containing logos must receive prior approval by SCDHHS.
2. Any claims stating that the MCO is recommended or endorsed by any public or private agency or organization, or by any individual, must receive prior approval by SCDHHS and must be certified in writing by the person or entity that is recommending or endorsing the MCO.
3. The MCO is allowed to directly and/or indirectly conduct Marketing activities in a doctor's office, clinic, pharmacy, hospital or any other place where health care 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 (e.g., allowable dates, times, locations, etc.).

4. All Marketing activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of Beneficiaries or the general community.
5. The MCO may provide approved Marketing and educational Materials for display and distribution by Providers. This includes printed material and audio/video presentations.
6. Upon request by a Medicaid Beneficiary, Marketing representatives may provide him or her with approved Marketing Materials.
7. MCOs must notify SCDHHS of all sponsorships; however, no approval or submission of sponsorship material is required. MCO sponsorships are not required to include the Healthy Connections logo on the third-party host organization's materials, even if the MCO's logo is on the materials.

B. Activities Which Are Not Permitted

1. When conducting Marketing activities, the MCO shall not assist a person in enrolling in a health plan.
2. The MCO (and any Subcontractors or representatives of the MCO) shall not engage in Marketing practices or distribute any Marketing Materials that misrepresent, confuse, or defraud Medicaid Beneficiaries. The MCO shall not misrepresent or provide fraudulent misleading information about the Medicaid program, SCDHHS and/or its policies.
3. The MCO may not directly or indirectly engage in door-to-door, telephone, email, text, or other cold call Marketing activities. Cold call Marketing activities are defined as any unsolicited personal contact by the MCO with a potential enrollee for the purposes of Marketing.
4. The MCO is prohibited from comparing their organization/plan to another organization/plan by name.

Beneficiary Marketing Education Materials

The SCDHHS and/or its designee will only be responsible for distributing general MCO Marketing Materials 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.

Marketing Events and Activities

Written notice to SCDHHS is required prior to MCOs conducting, sponsoring, or participating in Marketing 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.

All marketing activities are to be submitted through SharePoint using the Marketing Activities Submission Log. Notification of all activities must include the date, time, location and details. Submissions must be made to SCDHHS no later than noon (12 PM Eastern Time), four (4) business days prior to the scheduled event. South Carolina state holidays are excluded from being counted as a business day.

When conducting Marketing activities, the MCO may not initiate contact with members of the public or Beneficiaries, but may respond to contact initiated by the public or Beneficiary.

SCDHHS reserves the right to attend all Marketing activities/events. The MCO must secure the written permission of the business or event sponsor to conduct Marketing activities (this satisfies the “written Prior Approval” requirement of the MCO Contract) and make this document available to SCDHHS if requested. (Facsimile copies are acceptable.)

MCOs may conduct Marketing activities at events and locations including, but not limited to health fairs, health screenings, schools, churches, housing authority meetings, private businesses, 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.

Social Media Activities

MCOs are permitted to use social media. All social media sites must receive approval from SCDHHS before launching. All new, previously unapproved, content for social media marketing messages, as defined by CFR § 438.104, must be preapproved by SCDHHS. If the messages were already approved by SCDHHS on other marketing materials, they may be used for social media and do not require additional approval.

Health and wellness messages and third-party educational materials do not need approval by SCDHHS.

Once MCOs submit the proper written notification for conducting, sponsoring, or participating in Marketing activities and events, the MCO may post about the activity/event before, during, and after the activity/event but must adhere to the C.F.R and SCDHHS marketing policies and procedures in their messaging.

Standard template responses to social media inquiries are considered scripts and must receive approval from SCDHHS.

If an MCO’s parent corporation has a social media presence, any messaging to promote

SC-specific Medicaid events or messages are subject to SCDHHS approval and/or the SCDHHS Policy and Procedures Guide for Managed Care Organizations.

MCOs should include this disclaimer language on all social media sites, “The views and opinions expressed on this site are those of [INSERT MCO NAME HERE] and do not necessarily reflect the official policy or position of the South Carolina Department of Health and Human Services, nor any other agency of the State of South Carolina or the U.S. government.”

MCOs will consult with their legal team and appropriate parties regarding PHI protections, proactive messaging, and responses on social media.

All social media requests and submissions should be submitted via SharePoint. SCDHHS will respond to requests within five business days.

12.4 Marketing Material Submission Requirements

Section 12.4.1 through Section 12.4.2: 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), 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.

SCDHHS must prior approve all marketing materials prior to public use.

12.5 Marketing Material Distribution and Publication Standards and Requirements

For all cites in Section 12.5, please refer to the contract for all requirements between MCO and SCDHHS.

13.0 Reporting Requirements

13.1 General Requirements

Section 13.1: The MCO must certify and attest to the truthfulness, accuracy and completeness of the following required reporting:

1. Patient Centered Medical Home (PCMH) data
2. Capitated Rate Calculation Sheet (CRCS) data
3. Healthcare Effectiveness Data and Information Set (HEDIS)
4. Encounter data.

The report companion guide contains 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.

Section 13.1.1: Please see below for a list of all required reports, the report companion guide provides additional detail regarding specific format requirements and data elements.

REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
Section 2. CONTRACTOR Administrative Requirements		

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REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
1) QA Grid	Ad Hoc	As Necessary Returned weekly to MCO
2) Organizational Chart	Annually Ad Hoc	90 days after the end of a fiscal year; Within 10 business days of any change
3) Personnel Resumes	Ad Hoc	Within 10 business days of any change
Section 3. Eligibility and Enrollment		
1) Call Center Performance	Monthly	15 calendar days from the end of the month
2) Health Plan Disenrollment	Ad Hoc As Necessary	As Necessary
3) Nursing Home Notification	Ad Hoc As Necessary	As Necessary
4) Waiver Enrollment	Ad Hoc As Necessary	As Necessary
5) Hospice Enrollment	Ad Hoc As Necessary	As Necessary
6) 834 Report Layout ^[D]	Daily	Daily
7) Eligibility Redetermination ^[U]	Monthly	15 calendar days after the end of a period
Section 4. Services		
1) Additional Services	Ad Hoc As Necessary	As Necessary
2) Universal PA	Ad Hoc As Necessary	As Necessary
3) Makena/17P	Ad Hoc As Necessary	As Necessary
4) Universal Synagis PA	Ad Hoc As Necessary	As Necessary
5) Member Incentives	Ad Hoc As Necessary	As Necessary
Section 5. Care Coordination		

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REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
1) Care Management	Monthly	15 calendar days from the end of the month
2) Universal Newborn PA	Ad Hoc As Necessary	As Necessary
Section 6. Networks		
1) Geographic Service Area Submissions (GeoAccess)	Bi-Annual Ad Hoc	September 1 st & March 1 st ; As Necessary
2) Provider Network ^[M]	Weekly & Monthly	Weekly (Thursdays); Monthly (Thursday prior to cutoff each month)
Section 7. Payments		
1) Health Insurance Fee		
a) Certified copy of the CONTRACTOR's full Annual Fee Assessment	Annually	Within 60 days of date of notice from IRS
2) Patient Centered Medical Homes (PCMH)	Monthly	The 15 th day of the following month
3) Dual Medicare-Medicaid ^[D]	Monthly	The 15 th day of the following month
4) Deceased Members Receiving Premiums ^[D]	Monthly	The 15 th day of the following month
5) Manual Maternity Kicker	Monthly	The 15 th day of the following month
6) MCO Withhold ^[D]	Quarterly	30 calendar days after the end of a quarter
7) Medical Loss Ratio (MLR)	Annually	
8) RHC Wrap Payments	Quarterly Annually	No later than 60 days from the end of the quarter [¥] ; 60 days after the end of a fiscal year.
9) FQHC/ Prospective Payment System (PPS)	Quarterly Annually	No later than 60 days from the end of the quarter [¥] ; 60 days after the end of a fiscal year.
10) Premium Payment Adjustments ^[D]	Ad Hoc As Necessary	As Necessary
11) Audited Financial Statement	Annually	By July 1 st of each year

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REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
Section 8. Utilization Management		
1) Drug Utilization Review	Annually	
Section 9. Grievance & Appeal Procedures		
1) Member Grievance Log	Quarterly	30 calendar days after the end of a quarter
2) Member Appeal Log	Quarterly	30 calendar days after the end of a quarter
3) Provider Dispute Log	Quarterly	30 calendar days after the end of a quarter
Section 10. Third-Party Liability		
1) TPL Verification	Monthly	The 15 th day of the following month
2) TPL Cost Avoidance	Monthly	The 15 th day of the following month
3) TPL Coordination of Benefits (COB) Savings	Monthly	The 15 th day of the following month
4) TPL Recoveries	Monthly	The 15 th day of the following month
5) TPL Casualty Cases	Monthly	The 15 th day of the following month
Section 11. Program Integrity		
1) Subcontract submissions	Ad Hoc As Necessary	As Necessary
2) Program Integrity (PI) Fraud and Abuse Member	Ad Hoc As Necessary	As Necessary
3) PI Fraud and Abuse Provider	Ad Hoc As Necessary	As Necessary
4) Fraud Notification	Ad Hoc As Necessary	As Necessary
5) Complaint Case Notification	Ad Hoc As Necessary	As Necessary

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REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
6) SCDHHS Beneficiary Explanation of Medical Benefits (BEOMB)	Ad Hoc As Necessary	As Necessary
7) MCO Payment Suspension	Ad Hoc As Necessary	As Necessary
8) Termination Denial for Cause	Monthly	The 15 th day of the following month
9) Monthly MCO Fraud and Abuse	Monthly	The 15 th day of the following month
10) Quarterly MCO Fraud and Abuse	Quarterly	The 30 th day following the close of each quarter
11) Program Integrity (PI) Written Compliance Plan	Annually Ad Hoc	Within 90 days of contract and annually thereafter; 60 days prior to proposed change effective date; Submitted directly to Program Integrity
Section 12. Marketing Requirements		
1) Marketing Materials	Ad Hoc As Necessary	As Necessary
Section 13. Reporting Requirements		
2) Claims Payment Accuracy	Monthly	The 15 th day of the following month
3) Graduate Medical Education (GME)	Quarterly	The 30 th day following the close of each quarter
Section 14. Encounter Data		
1) Encounter Data	Monthly	By the end of the month for the previous month's encounters
2) Encounter Submission Summary	Monthly	The 15 th day of the following month
3) Capitation Rate Calculation Sheet (CRCS)	Quarterly	Within 121 days of the end of each calendar quarter
Section 15. Quality Assessment, Monitoring and Reporting		
1) Quality Assessment & Performance Improvement Projects ^Δ	Ad Hoc As Necessary	As Necessary
2) External Quality Review	Annually	Varies Scheduled annually by EQRO

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REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
3) Member Satisfaction Information [ⓑ]		
a) Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Annually	By July 1 st for previous calendar year
b) Supplemental Member Satisfaction Information	Optional	If conducted, by July 1 st for previous calendar year
4) HEDIS Reporting	Annually	By July 1 st for previous calendar year
5) Value Oriented Contracting/Alternative Payment Model (VOC)	Annually Ad Hoc	By April 1 st for previous calendar year. Within 3 business days of the date of request, unless otherwise specified by the Department.
Section 16. Department Responsibilities		
1.) MCO Q&A Grid	Ad Hoc	
Additional Reporting Requirements		
1. All CONTRACTOR Policies and Procedures	Annually	Within 90 days of the end of the fiscal year
<p>Notes:</p> <p>Ⓨ 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.</p> <p>△ Refer to Section 15 of the 2014 MCO Contract and Policy & Procedure Manual for additional details about Quality Assessment (QA) and/or Performance Improvement Projects (PIPs).</p> <p>ⓐ Report requirement is estimated to end October-2015 (Note: End date is estimated and is subject to change. Refer to the Managed Care Policy and Procedure Manual for details).</p> <p>[D] Report is Department-issued to Managed Care Organizations (MCOs) for action by MCO (e.g., action may include, but is not limited to: (1) validation of record, (2) reconciliation, (3) payment).</p> <p>[M] In addition to the monthly reports submitted to the Department, MCOs submit reports weekly (on Thursdays) to Maximus.</p> <p>ⓑ Refer to Section 15 of the 2014 MCO Contract and Policy & Procedure Manual for additional details about Member Satisfaction Information (i.e., CAHPS Surveys as primary survey; Additional tools for supplemental information purposes—these may include the use of additional Member surveys, anecdotal information gathered from Member or Provider interactions, grievance and appeals data, and Enrollment and Disenrollment information.).</p>		

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.

For all cites in Section 13.1.2 through Section 13.1.10.5, 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 14.1.6.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.1.6.3: 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 14.1.6.4 through Section 14.1.9.1, please refer to the contract for all requirements between MCO and SCDHHS.

14.2 Member Data

For all cites in Section 14.2, please refer to the contract for all requirements between MCO and SCDHHS.

14.3 Claims Data

For all cites in Section 14.3, please refer to the contract for all requirements between MCO and SCDHHS.

14.4 Electronic Transactions

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

14.5 Encounter Data

For all cites in Section 14.5.1 through Section 14.5.5.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.5.6 through 14.5.12.1: 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. Five thousand (5,000) record limit per file
2. Fifteen (15) files are allowed each day (maximum submission for any single day Monday through Saturday is 75,000 records).

3. Sunday submissions are not allowed.
4. Void encounters must be submitted in a separate file after the original encounter has received a 277CA response indicating the department's acceptance of the original encounter. Void and Regular encounters may be submitted on the same day. If the MCO elects to send both void and regular encounters on the same day, they must be in separate files from each other. All void encounters must be in one (1) file and regular encounters must be in a second file. Void and regular encounters **must not be** comingled within the same file.

Encounter data submitted to SCDHHS in most instances must appear in the same manner that the original claim was submitted and paid by the MCO. SCDHHS will 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 an MCO splits 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.

SCDHHS intake process for encounter submission when SCDHHS does not have the National Provider ID of the provider in question includes the use and submission of a Non-Par Provider file with the encounter data sent to the Department. File layouts for the Non-Par provider report may be found in the report companion guide.

Each time a Non-Par provider file is sent a single cumulative Non-Par provider file must be sent with the full encounter submission for the day. Each submitted Non-Par provider ID must remain that provider's Non-Par ID for the duration of the time the provider remains not enrolled with SCDHHS. Non-Par provider ID's must never be reused for new providers.

SCDHHS provides encounter companion guides on its website at <https://msp.scdhhs.gov/managedcare/> that further explain the Department's current electronic submission criteria. The Department's encounter edit code listing may be found in section 14.5 of the report companion guide.

MCO's must submit and SCDHHS must accept at least 97% of all initial encounters. Initial encounters are defined as an encounter accepted by SCDHHS no later than the

25th day of the month following claim payment by the MCO. A monthly report summarizing the MCO paid claims and the accepted and rejected encounters for the month of payment must be submitted to the Department. The template of this report may be found in section 14 of the Report Companion Guide the report name is Encounter Submission Summary. Reporting requirements include an explanation by encounter type if initial submission for any month is less than 97% complete.

14.6 Submission of Test Encounter Data

For all cites in Section 14.6, please refer to the contract for all requirements between MCO and SCDHHS.

14.7 Eligibility and Enrollment Exchange Requirements

For all cites in Section 14.7, please refer to the contract for all requirements between MCO and SCDHHS.

14.8 FQHC / RHC Encounter Reporting

For all cites in Section 14.8 through Section 14.8.1, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.8.2: 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 or its contractors 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.

FQHC

Beginning with dates of service on or after July 1, 2016 new contractual requirements include Prospective Payment System (PPS) methodology for FQHC providers. MCOs must pay FQHC providers based on the methodology reflected in the table below.

WRAP PAYMENT METHODOLOGY	
EFFECTIVE JULY 1, 2017	
FQHC	
Allowed CPT Codes (1)	Exclusions from FQHC Encounter Rate (3)
Billable as a Medical Encounter:	59025 (TC Modifier)
T1015	70000 - 79999 (TC Modifier)
99201-99205	70000 Series - 70% removed for Tech component (4)
99212-99215	90378
99241-99245	90630
99381-99385	90656
99391-99395	90657
Add. Codes for Bi-Annual Exams (Adults):	90658
99386	90620, 90621, 90670
99387	90662
99396	90672
99397	90673
Podiatry:	90685-90688
Standard E&M codes - see above	90707, 90710, 90715, 90716
Ophthalmology:	90732
92002	92250/TC
92004	92340
92012	93005
92014	93017
Chiropractic:	93041
98940-98942	93225
In-Home Services	93325
99341-99345	93880
99347-99350	93970
Domiciliary or Rest Home Services:	99050
99324-99328	99051
99334-99337	99217 - 99999 *
Skilled Nursing Facility Services:	A4264
99304-99310	J1050
99315-99316	J1950
99318	J7297
Family Planning Service (separate visit):	J7298
99401-99402	J7300
Postpartum Care:	J7301
59430	J7307
Health Risk Assessment (Foster Care):	80305
96160, 96161	80307
MNT/Nutritional Counseling/Obesity Initiative:	G0480
97802-97803	Q2035 - Q2039
	Q3014
Billable as a Behavioral Health Encounter: (2)	
90791, 90792	
90832-90834, 90836-90838	
90839	
90847, 96101	
T1015/HE	
* - Any code in this range unless included in the "Allowed CPT Code" column.	
FOOTNOTES	
(1) Allowed CPT Codes are those services considered as an eligible FQHC encounter service. They are includable in the WRAP "count".	
(2) Behavioral Health Services codes that are considered as an eligible FQHC encounter. A behavioral health code can be provided and billed on the same date of service as a medical service. Both services/encounters will be included in the WRAP settlement.	
(3) Excludable procedure codes billed under MCO arrangements are not includable in the WRAP payment calculations and thus are carved out and reimbursed separately outside of the FQHC encounter rate. For any procedure code billed outside of those identified under sections (1), (2), and (3), payment of these codes are included in the FQHC encounter service rate and thus should not be separately reimbursed.	
(4) The professional component of the 70000 series procedure codes are included in the FQHC encounter service rate and thus should not be separately reimbursed.	
5) Current policy allows dietitian services as incident to a physician or mid-level service. That is, the beneficiary is seen by the provider (physician or mid-level) and dietitian on the same day, one encounter can be billed for the services received that day. Dietitian services cannot be billed independently from the services of the physician or mid-level.	
6) Group services should never be billed using the encounter rate. A billable encounter is a face-to-face, one-on-one service with a physician or mid-level practitioner.	
7) Procedure codes will be reviewed annually to determine if updates are required in either billable encounter codes or excludable services.	

PPS ARM reimbursement rates are shared with all MCOs annually a month prior to the end of each fiscal year. This document indicates all current encounter reimbursement rates that must be paid and the FQHCs eligible for this reimbursement methodology. MCOs and FQHCs through their contractual relationship determine when full payment is made for services rendered by the FQHC. Departmental preference is for full payment initially when the FQHC provides services. SCDHHS understands that reconciliation at a later date may initially be necessary while claims processing systems are modified to address claims payment logic. MCOs should only pay for codes that are reflected in the reimbursement methodology chart reflected above.

MCO Encounter Submission of FQHC Data

MCOs may submit the full encounter payment to SCDHHS through routine MCO encounter submission provided the submitted encounter does not:

1. Have a line paid amount that is negative.

SCDHHS can capture encounters with zero line payments. If the MCO encounter submission includes all applicable coding with no payment or with the FFS payment for codes reflected in the chart above as excluded from the FQHC encounter rate the department will be able to accept and process the encounter.

Reporting Requirement

1. The Medicaid MCO shall submit a report, quarterly, to its SharePoint quarterly library, all paid encounter/claim data, by date of service, for all services rendered by FQHCs for review and agency auditing purposes to confirm the entire encounter rate was paid to all participating FQHCs. The Contractor shall submit the name of each FQHC and detailed claims/encounter data paid to each FQHC. 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 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'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 claims data not available or processed when the applicable quarter was originally run.

Transmission requirements remain the same as the 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 and detailed Medicaid claims/encounter data (i.e., Medicaid recipient data, payment data, service/CPT codes) paid to each FQHC by month of service to the Department for federally mandated reconciliation and auditing purposes. Encounter detail data and summary data shall be provided to SCDHHS as two (2) separate data spreadsheets in one Microsoft Excel workbook. 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>.

RHC

For Rural Health Clinic providers 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 encounter/claim data, by date of service, for all services rendered by RHCs for supplemental payment determination (Wrap-Around methodology) reconciliation purposes. Services eligible for Wrap-around methodology must meet fee-for-service coverage requirements. The Contractor shall submit the name of each RHC and detailed Medicaid encounter data paid to each 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 RHC's fiscal year end, an annual reconciliation of MCO payments and services to allowable reimbursement based on the 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 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 RHC and detailed Medicaid claims/encounter data (i.e., Medicaid recipient data, payment data, service/CPT codes) paid to each RHC by month of service to the Department for federally mandated

reconciliation and auditing purposes. Encounter detail data and summary data shall be provided to SCDHHS as two (2) separate data spreadsheets in one Microsoft Excel workbook. 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>.

14.9 Errors and Encounter Validation

For all cites in Section 14.9.1 through Section 14.9.1.1.3, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.9.1.1.4: The MCO must submit encounters by the 25th of each month after claim payment for the encounter to be included as an initial encounter.

For all cites in Section 14.9.1.2 through Section 14.9.5.2.1, please refer to the contract for all requirements between MCO and SCDHHS.

14.10 Data Validation

For all cites in Section 14.10.1 through Section 14.10.7, please refer to the contract for all requirements between MCO and SCDHHS.

Section 14.10.8 through Section 14.10.8.3: 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 as well as an annual CRCS report for rate setting and base data verification purposes. 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. Quarterly CRCS reports are due within 121 days of the end of each calendar quarter. The annual CRCS report will be due the third Friday in January of each year. If there are delays in the MCO’s receiving the previous quarter’s CRCS analysis extensions of the time frame for CRCS submission are thirty (30) days from the SCDHHS contractor’s submission of the previous quarters CRCS results. The following reporting schedules are used:

Quarterly CRCS Reporting Schedule*		
SERVICE DATES OF CRCS REPORT	THROUGH PAID DATE	CRCS REPORT DUE DATE
January 1- March 31	Claims Paid through June 30	July 31
April 1- June 30	Claims Paid through Sept 30	October 31
July 1 – September 30	Claims Paid through December 31	January 31

Quarterly CRCS Reporting Schedule*		
SERVICE DATES OF CRCS REPORT	THROUGH PAID DATE	CRCS REPORT DUE DATE
October 1 – December 31	Claims Paid through March 31	April 30
Annual CRCS Reporting Schedule*		
SERVICE DATES OF CRCS REPORT	THROUGH PAID DATE	CRCS REPORT DUE DATE
July 1- June 30 (Previous Fiscal Year)	Claims Paid through December	Third Friday in January of each year
*Encounter data must be submitted prior to the 25 th of the month in order for SCDHHS and Milliman to have the data for use in CRCS analysis.		

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. 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 liquidated damages.

CRCS reports must be uploaded to the MCO's SharePoint CRCS library. The naming convention of the report must be as follows: (Calendar Year of Report)(Calendar Quarter of Report/Annual Report)(MCO Name)(CRCS Submission). Example: 2015Q1 ACME MCO CRCS Submission. Additionally the MCO must notify their SCDHHS assigned liaison that the information has been uploaded to the site.

14.11 System and Information Security and Access Management Requirements

For all cites in Section 14.11, please refer to the contract for all requirements between MCO and SCDHHS.

14.12 Subcontractor(s) and Encounter Data Reporting

For all cites in Section 14.12, please refer to the contract for all requirements between MCO and SCDHHS.

14.13 Periodic Audits

For all cites in Section 14.13, please refer to the contract for all requirements between MCO and SCDHHS.

14.14 Future Encounter Data Reporting Requirements

For all cites in Section 14.14, please refer to the contract for all requirements between MCO and SCDHHS.

15.0 Quality Management and Performance

15.1 General Requirements

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

15.2 Quality Assurance Committee

For all cites in Section 15.2, please refer to the contract for all requirements between MCO and SCDHHS.

15.3 Member Satisfaction Survey

The MCO must contract with an NCQA-Certified HEDIS Survey Vendor to administer HEDIS CAHPS surveys. The HEDIS CAHPS surveys must be administered in accordance with NCQA's *HEDIS Volume 3: Specifications for Survey Measures* for the reporting year. The MCO must instruct its survey vendor to indicate to NCQA that the MCO wants to publicly report its data.

To facilitate the submissions of the quality measures by the Department to CMS, the MCO must implement and submit to the Department results from all three of the following CAHPS surveys:

- CAHPS Health Plan Survey, Adult Version
- CAHPS Health Plan Survey, Child Version (without Children with Chronic Conditions questions)
- CAHPS Health Plan Survey, Child Version (with Children with Chronic Conditions questions)

The Department shall provide a Data Submission Protocol to the MCO, on or before April 1 of each year, describing specific procedures for the submission of CAHPS data.

The MCO must submit information as specified in the Data Submission Protocol. The required data submissions will include, at a minimum:

- Final CAHPS data submission to NCQA (IDSS)
- CAHPS Survey Data Files:
- NCQA Member-Level Data Files
- State-Specific Member-Level Data Files, if applicable
- MCO-Specific Survey Instruments
- CAHPS Final Audit Report (FAR)
- CAHPS Final Report from the CAHPS vendor

15.4 Quality Performance Measures

The MCO is 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 reporting year. SCDHHS may issue additional guidelines related to the inclusion of retired measures for any reporting period.

The 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. All audits must be conducted according to NCQA's *HEDIS Compliance Audit: Standards, Policies, and Procedures, Volume 5*. The audit scope must include, at a minimum, all SCDHHS required measures for the South Carolina Medicaid population. Audits must be completed in accordance with NCQA's timeline.

The Department shall provide a Data Submission Protocol to the MCOs, on or before April 1 of each year, describing specific procedures for the submission of HEDIS information. The MCO must submit information as specified in the Data Submission Protocol.

If additional quality performance measures are required in the future, the Department will provide notice to the health plans of the new requirements.

15.5 Quality Withhold and Bonus Program

The Department will execute a withhold of capitation rates equal to 1.5% of the overall sum of rates, not including teaching supplements and gross level adjustments. 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 Department will use the MCO's own HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program.

Beginning with measurement year 2016, SCDHHS will use Quality Indices in three clinical areas, rather than individual HEDIS measures, to calculate the withhold return. The Quality Indices for measurement years 2016 and 2017 are: (1) Diabetes Care, (2) Women’s Health, and (3) Pediatric Preventative Care.

SC Medicaid MCO Quality Indices, Measurement Years 2016 and 2017

<u>HEDIS MEASURE</u>	<u>WEIGHT</u>	<u>HEDIS ABBREVIATION</u>
<u>Index 1: Diabetes</u>		
Hemoglobin A1c (HbA1c) Testing	45%	CDC
HbA1c Poor Control (>9.0%)	15%	CDC
Eye Exam (Retinal) Performed	20%	CDC
Medical Attention for Nephropathy	20%	CDC
<u>Index 2: Women’s Health</u>		
Prenatal Care, <i>Timeliness of Prenatal Care</i>	40%	PPC
Breast Cancer Screening	20%	BCS
Cervical Cancer Screening	20%	CCS
Chlamydia Screening in Women, <i>Total</i>	20%	CHL
<u>Index 3: Pediatric Preventative Care</u>		
Well-Child Visits in the First 15 Months of Life (w15), <i>6+ Visits</i>	30%	W15
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	30%	W34
Adolescent Well-Care Visits (AWC)	30%	AWC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: <i>BMI Percentile, Total</i>	10%	WCC

Each Quality Index will represent 1/3 of the MCO’s overall withhold, and each Quality Index will be evaluated independently.

Calculating the Index Score:

Step 1: Assign a point value to each of the HEDIS measures within the Quality Index based on the table below:

<u>HEDIS SCORE</u>	<u>POINT VALUE</u>
< 10 Percentile	1 Point
10-24 Percentile	2 Points
25-49 Percentile	3 Points

HEDIS SCORE	POINT VALUE
50-74 Percentile	4 Points
75-90 Percentile	5 Points
> 90 Percentile	6 Points

For the purposes of determining the HEDIS percentile score, SCDHHS will use HHS-Atlanta data from the NCQA *Quality Compass* that was released during the measurement year. For example, performance for the 2016 measurement year will be evaluated during 2017 using the *Quality Compass* released by NCQA on September 30, 2016.

Step 2: Multiply the number of points for each score, as determined in Step 1, by the weight assigned to each measure.

Step 3: Sum each of the weighted scores calculated in Step 2 for the Quality Index to calculate the Quality Index Score.

Withholds will be returned based on the following parameters:

INDEX SCORE	WITHHOLD ACTION
1 Point	Index withhold amount forfeited and eligible for liquidated damages as described below.
1.01 to 1.99 Points	Index withhold amount forfeited.
2.00 to 2.99 Points	75% of Index withhold amount forfeited.
3.00 to 3.99 Points	25% of Index withhold amount forfeited.
4.00 to 4.99 Points	Full Index withhold amount returned to plan.
5.00 to 6.00 Points	Full Index withhold amount returned to plan and plan is eligible for bonus pool funds.

Information related to payout of the bonus pool will be made available to MCOs annually.

Liquidated damages up to \$500,000 per index may be assessed in the event that the Quality Index Score is 1 (the minimum score that can be assessed, in the case that each measure within a Quality Index is scored at less than the 10th percentile).

15.6 Alternative Payment Models (APM)

To better align Alternative Payment Model (APM) requirements with other payers, SCDHHS is adopting many of the components of the APM Framework developed by the Health Care Payment Learning and Action Network (LAN).

To qualify as an APM, a network contract must have some component of payment linked to Provider performance. MCOs are encouraged to pursue innovation in the pursuit of negotiating value-oriented contracts. Generally, APMs will be consistent with one of the following LAN Categories:

- Category 1, as defined by LAN, includes fee-for-service payments that are not linked to quality or value. These Provider contracts are not considered APMs.
- Category 2A & 2B: Payments for infrastructure and operations (2A) and reporting (2B) are not considered APM payments by the Department.
- Category 2C & 2D: Provider contracts that include rewards or rewards & penalties for performance shall be considered APM contracts.
- Category 3: Bundled and episode of care payments shall be considered APM contracts, so long as quality of care requirements are included in the Provider contract.
- Category 4: Sub-capitation arrangements shall be considered APMs, so long as quality of care requirements are included in the Provider contract.

Annually, no later than April 30, each MCO shall submit to the Department a certification of the percentage of payments made pursuant to alternative payment models. The APM percent shall be calculated by dividing the total dollars paid pursuant to a APM by the total dollars spent by the MCO on healthcare services.

Payments for the following services may be excluded from the APM calculation:

- Claims paid through the pharmacy benefit.
- Claims made to durable medical equipment providers.
- Payments made to Federally Qualified Health Centers (FQHCs) based on the Prospective Payment System (PPS)

If, after the submission of the APM percentage to the Department, the MCO finds that extenuating circumstances prevented the MCO from achieving the APM target due to Department policy changes, the MCO may request for a reconsideration such that claims costs for those providers to be excluded from the denominator of the APM calculation.

$$APM\% = \frac{\text{Dollars Spent Pursant to APM}}{\text{Total Dollars Spent on Healthcare Services}} \\ \text{minus the exceptions listed above}$$

The APM calculation should include all claims or capitation payments with a date of service during the measurement period (January 1 through December 31) that are received by the MCO by March 31.

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 APM requirement.

The Department reserves the right to audit any contract claimed to qualify as APM as well as any payments claimed to have been made pursuant to a APM contract. The determination for whether or not a Provider contract qualify as a APM shall rest solely with the Department.

15.7 NCQA Accreditation Standards and Requirements

For all cites in Section 15.8, please refer to the contract for all requirements between MCO and SCDHHS.

15.8 External Quality Review (EQR)

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:

- A. 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, based on the following;
- B. 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.

- C. 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.
- D. Ensuring the MCO has policies and procedures for approval of new Subcontractors and termination or suspension of a Subcontractor.
- E. Ensuring the MCO has a mechanism for reporting Quality deficiencies which result in suspension or termination of a Subcontractor.
- F. Ensuring there are written policies and procedures for assigning every Medicaid MCO Member a Primary Care Provider.
- G. 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.
- H. Ensuring the MCO has a referral system for Medically Necessary, specialty, secondary and tertiary care.
- I. 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.
- J. 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.
- K. 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.
- L. 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.
- M. Ensuring medical records are readily available for MCO-wide QA and UM activities and provide adequate medical and clinical data required for QA/UM.

- N. 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.
- O. 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.
- P. 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
- Q. A Processes to identify utilization problems and undertake corrective action
- R. An emergency room log, or equivalent method, specifically to track emergency room utilization and Prior Authorization (to include denials)

- S. Processes to assure abortions comply with 42 CFR 441 subpart E-Abortions, and hysterectomies and sterilizations comply with 42 CFR 441 subpart F-Sterilizations.
- T. 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
- U. 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.
- V. 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

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.

15.9 Provider Preventable Conditions

The MCO must ensure that the following Other Provider Preventable Conditions (OPPCs) are included in its non-payment policy for Provider preventable conditions (PPCs).

- Post-operative 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.

Section 16.3.1: A template of the Managed Care Q&A grid is available to MCOs in the Managed Care Report Companion Guide Section 2.

For all cites in Section 16.3.2, 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

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

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 under Mutual Agreement

For all cites in Section 17.1, please refer to the contract for all requirements between MCO and SCDHHS.

17.2 Termination by Department for Breach

For all cites in Section 17.2, please refer to the contract for all requirements between MCO and SCDHHS.

17.3 Termination for Unavailability of Funds

For all cites in Section 17.3, please refer to the contract for all requirements between MCO and SCDHHS.

17.4 Termination for CONTRACTOR Insolvency, Bankruptcy, Instability of Funds

For all cites in Section 17.4, please refer to the contract for all requirements between MCO and SCDHHS.

17.5 Termination by the CONTRACTOR

For all cites in Section 17.5, please refer to the contract for all requirements between MCO and SCDHHS.

17.6 Termination for Loss of Licensure or Certification

For all cites in Section 17.6, please refer to the contract for all requirements between MCO and SCDHHS.

17.7 Termination for Noncompliance with the Drug Free Workplace Act

For all cites in Section 17.7, please refer to the contract for all requirements between MCO and SCDHHS.

17.8 Termination for Actions of Owners / Managers

For all cites in Section 17.8, please refer to the contract for all requirements between MCO and SCDHHS.

17.9 Non-Renewal

For all cites in Section 17.9, please refer to the contract for all requirements between MCO and SCDHHS.

17.10 Termination Process

For all cites in Section 17.10, please refer to the contract for all requirements between MCO and SCDHHS.

17.11 Amendments and Rate Adjustments

For all cites in Section 17.11, 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 audits done by the states External Quality Review (EQR).

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 18.4.15, 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. The MCO must disclose this information to the SCDHHS when requested. 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

Physician incentive plans that place physicians at substantial financial risk must conduct enrollee surveys in compliance with 42 CFR 417.479(g) (1).

SCDHHS has the authority to utilize the Medicaid version of CAHPS to meet the survey requirement. MCOs, upon completion of an 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.

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 18.4.17, 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 HIPAA Business Associate

For all cites in Section 19.3, please refer to the contract for all requirements between MCO and SCDHHS.

19.4 Safeguarding Information

For all cites in Section 19.4. through Section 19.4.2, please refer to the contract for all requirements between MCO and SCDHHS.

Section 19.4.3: On occasion MCOs must talk with authorized representatives and/or the 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 an employee of the South Carolina Department of Health and Human Services (SCDHHS) and/or the South Carolina Department of Social Services (SCDSS) validates the Medicaid beneficiary information the MCO must act on the information provided by the state representative from SCDHHS and/or DSS.

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 19.4.4 through Section 19.4.6, 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.

Actuarially Sound Capitation Rates – Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in 42 CFR 438.4 paragraph (b) of this section.

CMS review and approval of actuarially sound capitation rates - Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:

- (1) Have been developed in accordance with standards specified in §438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
- (2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
- (3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in §§438.206, 438.207, and 438.208.
- (4) Be specific to payments for each rate cell under the contract.
- (5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
- (6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in §438.3(c)(1)(ii) and (e).
- (7) Meet any applicable special contract provisions as specified in §438.6.
- (8) Be provided to CMS in a format and within a timeframe that meets requirements in §438.7.
- (9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard, as calculated under §438.8, of at least 85 percent for the rate year. The capitation rates may be developed in such a way

that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard greater than 85 percent, as calculated under §438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-benefit costs.

Additional Services – A covered service provided by the CONTRACTOR which is currently a non-covered service(s) by the SC State Plan for Medical Assistance or is an additional Medicaid covered service furnished by the CONTRACTOR to Medicaid Managed Care Program members for which the CONTRACTOR receives no additional capitated payment, and is offered to members in accordance with the standards and other requirements set forth in the Contract.

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.

Administrative Services Contracts or Administrative Services Subcontracts – Subcontracts or agreements that include, but are not limited to:

- Any function related to the management of the Medicaid Managed Care Contract with the Department.
- Claims processing including pharmacy claims.
- Credentialing including those for only primary source verification.
- All management Service Agreements.
- All Service Level Agreements with any Division of Subsidiary of a corporate parent owner.

Adverse Benefit Determination – An adverse benefit determination includes:

- (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
- (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 an MCO, PIHP, or PAHP to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeal.
- (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network.
- (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Ambulance Services – Ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health (42 CFR §422.113(a)).

American Health Information Management Association (AHIMA) – A professional organization for the field of effective management of health data and health record needed to deliver quality healthcare to the public management.

American National Standards Institute (ANSI) – The American National Standards Institute is a private non-profit organization that oversees the development of voluntary consensus standards for products, services, processes, systems, and personnel in the United States.

ANSI ASC X12N 837P – The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837P (Professional) Version 5010A1 is the current electronic claim version.

Appeal – A request for review of an action, as adverse benefit determination is defined in 42 CFR § 438.400.

Applicant – An individual:

- Seeking Medicaid eligibility through written application.
- Whose signed application for Medicaid has been received by the South Carolina Department of Health and Human Services (SCDHHS).

Authorized Representative – An Authorized Representative is an individual granted authority to act via SCDHHS Form 1282 ME, Authorization for Release of Information and Appointment of Authorized Representative for Medicaid Applications Reviews and Appeals, who is acting for the Applicant/Beneficiary/MCO member with the Applicant/Beneficiaries'/MCO member's knowledge and consent and who has knowledge of his circumstances.

Behavioral Health – A state of health that encompasses mental, emotional, cognitive, social, behavioral stability including freedom from substance use disorders.

Behavioral Health Provider – Individuals and/or entities that provide Behavioral Health Services.

Behavioral Health Services – The blending of mental health disorders and/or substance use disorders prevention in treatment for the purpose of providing comprehensive services.

Beneficiary – An individual who is Medicaid Eligible.

Benefit or Benefits – The health care services set forth in the Contract, for which the CONTRACTOR has agreed to provide, arrange, and be held fiscally responsible. Benefit(s) are also referenced as Core Benefits or Covered Services.

Bonus – A Bonus Pool is a payment that involves undistributed funds accumulated from Withhold amounts forfeited by the CONTRACTORS.

Business Days – Monday through Friday from 9 A.M. to 5 P.M., excluding State holidays.

CAHPS – The Consumer Assessment of Healthcare Providers and Systems is a standardized survey of patients' experiences with ambulatory and facility-level care established by the Agency for Healthcare Research and Quality.

Calendar Days – All seven days of the week (i.e., Monday, Tuesday, Wednesday, Thursday, Friday, Saturday and Sunday).

Capitation Payment – The monthly payment paid by the SCDHHS to a CONTRACTOR for each enrolled Medicaid Managed Care Program member for the provision of benefits during the payment period.

Care Coordination – The manner or practice of planning, directing and coordinating health care needs and services of Medicaid MCO Members.

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

Care Management – Care management is a set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aims of improving patients' functional health status, enhancing coordination of care, eliminating duplication of services and reducing the need for expensive medical services (NCQA).

Case – An event or situation.

Case Management – A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes (CMSA, n.d.).

Case Management Society of America (CMSA) – A non-profit association dedicated to the support and development of the profession of case management (www.cmsa.org).

Case Manager – The individual responsible for identifying and coordinating services necessary to meet service needs of Medicaid Managed Care Program members.

Care Plan – A plan of care based on member assessment by a qualified health professional. The care plan has four (4) elements:

- (1) Identification of problem(s) or diagnosis.
- (2) The statement of approach for solving the problem(s).
- (3) The statement of the expected benefit to the patient.
- (4) Evaluation of the patient's response and readjustment of care provision as necessary.

Centers for Medicare and Medicaid Services (CMS) – Centers for Medicare and Medicaid Services

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.

Claim – A bill for services, a line item of services, or all services for one recipient within a bill.

Clean Claim – Claims that can be processed without obtaining additional information from the Provider of the service or from a third party.

CMS 1500 (or its successor) – A universal claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-04 (or its successor).

Code of Federal Regulation (CFR) – The Code of Federal Regulations (CFR) is an annual codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the Federal Government.

- The CFR is divided into fifty (50) titles representing broad areas subject to Federal regulation.
- Each Title is divided into chapters that are assigned to agencies issuing regulations pertaining to that broad subject area. Each chapter is divided into parts and each part is then divided into sections -- the basic unit of the CFR.

- The purpose of the CFR is to present the official and complete text of agency regulations in one organized publication and to provide a comprehensive and convenient reference for all those who may need to know the text of general and permanent Federal regulations.
- The CFR is keyed to and kept up-to-date by the daily Federal Register. These two publications must be used together to determine the latest version of any given rule. When a Federal agency publishes a regulation in the Federal Register, that regulation usually is an amendment to the existing CFR in the form of a change, an addition, or a removal.

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 CONTRACTOR with a potential member for the purpose of marketing (42 CFR § 438.104)

Compliance Officer – The individual responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract and who reports directly to the Chief Executive Officer (CEO) and the Board of Directors.

Compliance Plan – A collection of written policies, procedures, and standards of conduct that articulate the CONTRACTOR's commitment to comply with all applicable requirements and standards under the contract, and all Federal and State requirements.

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:

- Outpatient Hospital services,
- Rural Health Clinic (RHC) services,
- Federally Qualified Health Centers (FQHC) services,
- Other laboratory and X-ray services,
- Nursing Facility (NF) services,
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services,
- Family Planning services,
- Physician services; and
- 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 – Activities that ensure a continuum approach to treating and providing health care services to Medicaid Managed Care Members consistent with 42 CFR 438.208, the provisions outlined in this Contract and the Managed Care Policy and Procedure Guide. This includes, but is not limited to:

- Ensuring appropriate referrals, monitoring, and follow-up to providers within the network,
- Ensuring appropriate linkage and interaction with providers outside the network,
- Processes for effective interactions between Medicaid Managed Care Members, in-network and out-of-network providers and identification and resolution of problems if those interactions are not effective or do not occur.

Contract Dispute – A circumstance whereby the CONTRACTOR and SCDHHS are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under the Contract.

Conviction or Convicted – A judgment of conviction has been entered against an individual or entity by a Federal, State or local court regardless of whether:

- There is a post-trial motion or an appeal pending, or
- The judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed;
- A Federal, State or local court has made a finding of guilt against an individual or entity;
- A Federal, State or local court has accepted a plea of guilty or nolo contendere by an individual or entity;
- An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of conviction has been withheld.

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. Also, Core benefits are referred to as Benefit(s) and Covered Services.

Corrective Action Plan (CAP) – A narrative of steps taken to identify the most cost effective actions that can be implemented to correct errors causes. The SCDHHS requirements include, but are not limited to:

- Details of all issues and discrepancies between specific contractual, programmatic and/or security requirements and the CONTRACTOR's policies,

practices and systems.

- The CAP must also include timelines for corrective actions related to all issues or discrepancies identified, and be submitted to the SCDHHS for review and approval.

CONTRACTOR – The domestic licensed HMO (“MCO”) that has executed a formal agreement with the SCDHHS to enroll and serve Medicaid Managed Care Program members under the terms of this contract. The term CONTRACTOR shall include all employees, Subcontractors, agents, volunteers, and anyone acting on behalf of, in the interest of, or for a CONTRACTOR.

Covered Services – Services included in the South Carolina State Plan for Medical Assistance and covered under the Contract. Also, Covered Services are referred to as Benefits or Covered Benefits.

Credentialing – The CONTRACTOR’s determination as to the qualifications and ascribed privileges of a specific Provider to render specific health care services.

Credible Allegation of Fraud – A credible allegation of fraud may be an allegation, which has been verified by the State. Allegations are considered to be credible when they have indicia of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. Sources include, but are not limited to the following:

- Fraud hotline complaints.
- Claims data mining.
- Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Current Procedural Terminology (CPT) – Medical nomenclature used to report medical procedures and services under public and private health insurance programs (American Medical Association, 2016).

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.

Discovery or Discovered – Identification by the CONTRACTOR, any State Medicaid agency official or designated entities, the Federal Government, or the provider of an overpayment, and the communication of that overpayment finding or the initiation of a

formal recoupment action without notice as described in §42 CFR 433.136 when discovery of overpayment occurs and its significance.

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.

Direct Marketing (a.k.a. Cold Call or Cold Calling) – 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 Managed Care plan.

Department Appeal Regulations – Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 and S.C. Code Ann. §§1-23-310 et seq. (2006, as amended).

Dual Eligible (a.k.a. Dual Eligibles) – Individuals that are enrolled in both Medicaid and Medicare programs and receive benefits from both programs.

Dual Diagnosis or Dual Disorders – An individual who has both a diagnosed mental health problem and a problem with alcohol and/or drug use.

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.

Enrollee – A Medicaid beneficiary who is currently enrolled in the State’s Medicaid Managed Care Program, specifically a Managed Care Organization (MCO). Other Managed Care Programs may include, but are not limited to: PIHP, PAHP, or PCCM (42 CFR §438.10 (a)).

Enrollment – The process by which a Medicaid Eligible selects or is assigned to an MCO.

Enrollment (Voluntary) – The process in which an applicant/recipient selects a CONTRACTOR and goes through an educational process to become a Medicaid Managed Care Program member of the CONTRACTOR.

Excluded Services – Medicaid services not included in the CONTRACTOR's Core Benefits and reimbursed fee-for-service by the State.

Exclusion – Items or services furnished by a specific provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid.

External Quality Review (EQR) – The analysis and evaluation by an EQR 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.

Federal Poverty Level (FPL) – A measure of income level issued annually by the Department of Health and Human Services.

Federal Financial Participation (FFP) – Any funds, either title or grant, from the Federal Government.

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. A FQHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A FQHC provides a wide range of primary care and enhanced services in a medically underserved Area.

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

Final Audit Report – The Final Audit Report (FAR) is provided by an NCQA-licensed audit organization (LO) as part of an NCQA HEDIS Compliance Audit conducted by an NCQA-Certified HEDIS Compliance Auditor (CHCA).

Final Written Notice – That written communication, immediately preceding the first level of formal administrative or judicial proceedings, from the CONTRACTOR, a Medicaid agency official or their designated entities that notifies the provider of the State's overpayment determination and allows the provider to contest that determination, or that notifies the CONTRACTOR or the State Medicaid agency of the filing of a civil or criminal action.

Fraud – In accordance with §42 CFR 455.2 Definitions, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Fraud Waste Abuse (FWA) – FWA is the collective acronym for the terms fraud, waste and abuse.

Full-Time Equivalent (FTE) – A full time equivalent position.

Grievance – An expression of dissatisfaction about any matter other than an adverse benefit determination. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.

Health 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.

At a minimum, for hospitals and mental health hospitals, the medical health record must include:

- (1) Identification of the beneficiary.
- (2) Physician name.
- (3) Date of admission and dates of application for and authorization of Medicaid benefits if application is made after admission; the plan of care (as required under 456.172 (mental hospitals) or 456.70 (hospitals)).
- (4) Initial and subsequent continued stay review dates (described under 456.233 and 465.234 (for mental hospitals) and 456.128 and 456.133 (for hospitals)).
- (5) Reasons and plan for continued stay if applicable.
- (6) Other supporting material the committee believes appropriate to include.

For non-mental hospitals only:

- (1) Date of operating room reservation.
- (2) Justification of emergency admission if applicable.

Healthcare Common Procedure Coding System (HCPCS) – Healthcare Common Procedure Coding System, HCPCS was established in 1978 to provide a standardized coding system for describing the specific items and services provided in the delivery of health care. Such coding is necessary for Medicare, Medicaid, and other health insurance programs to ensure that insurance claims are processed in an orderly and consistent manner. Initially, use of the codes was voluntary, but with the implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) use of the HCPCS for transactions involving health care information became mandatory.

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.

Healthcare Effectiveness Data and Information Set (HEDIS) - A widely used set of performance measures in the managed care industry, developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS was designed to allow consumers to compare health plan performance to other plans and to national or regional benchmarks. Although not originally intended for trending, HEDIS results are increasingly used to track year-to-year performance. HEDIS is one component of NCQA's accreditation process, although some plans submit HEDIS data without seeking accreditation. An incentive for many health plans to collect HEDIS data is a Centers for Medicare and Medicaid Services (CMS) requirement that health maintenance organizations (HMOs) submit Medicare HEDIS data in order to provide HMO services for Medicare enrollees under a program called Medicare Advantage.

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.

Home and Community Based Services (HCBS) – In-home or community-based support services that assist persons with long term care needs to remain at home as authorized in an approved 1915(c) Waiver or 1915(i) State Plan.

Hospital Swing Beds – Hospitals participating in both the Medicaid and Medicare Programs, in addition to providing an inpatient hospital level of care, may also provide nursing facility levels of care and be reimbursed as “swing bed” hospitals. A swing bed hospital must be located in a rural area, have fewer than one hundred (100) inpatient beds exclusive of newborn and intensive care type beds, and be surveyed for compliance by DHEC and certified as meeting Federal and State requirements of participation for swing bed hospitals.

HHS – United States Department of Health and Human Services.

ICD – International Classification of Disease, Clinical Modification,

Improper Payment – Any payment that is made in error or in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements;

- To an ineligible recipient,
- For ineligible goods or services,
- For goods or services not received (except for such payments where authorized by law),
- That duplicates a payment, or
- That does not account for credit for applicable discounts.

Incentive Arrangement – Any payment mechanism under which a MCO or subcontractor may receive additional funds beyond premium and/or claim payment.

Inmate – On who is housed 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. Pursuant to 42 CFR § 435.1010, an inmate of a public institution is defined as "a person living in a public institution", and a public institution is defined as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control."

Insolvency – A financial condition in which a CONTRACTOR's assets are not sufficient to discharge all its liabilities or when the CONTRACTOR is unable to pay its debts as they become due in the usual course of business.

Institutional Long Term Care – A system of health and social services designed to serve individuals who have functional limitations which impair their ability to perform activities of daily living (ADLs). This includes care and/or services provided in a facility that is licensed as a nursing facility, and/or hospital that provides swing bed or Administrative Days.

Legal Representative – A “Legal Representative” is a person who has been granted legal authority to look after another’s affairs, such as an attorney, executor, administrator, holder of power of attorney, etc.

Limited English Proficiency – A potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

List of Excluded Individuals/Entities (LEIE) – The HHS-OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that provides information about parties excluded from Medicare, Medicaid, and all other Federal health care programs. The LEIE website is located at <http://www.oig.hhs.gov/fraud/exclusion.asp> and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match by entering the Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by the provider; however, the downloadable version does not contain SSNs or EINs.

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 42 CFR Part 489; or (2) Any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) Makes the services it provides to its Medicaid members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid Recipients within the area serviced by the entity; and (b) Meets the solvency standards of 42 CFR §438.116. This includes any of the entity’s employees, affiliated providers, agents, or contractors.

Managed Care Plan – The term "Managed Care Plan" is interchangeable with the terms "CONTRACTOR", "Managed Care Organization" (MCO), "Health Plan", "Plan", or "Health Maintenance Organization" (HMO).

Marketing – Any communication, from the CONTRACTOR to a Medicaid recipient who is not enrolled in that entity, that can be reasonably interpreted as intended to influence the recipient to enroll in that particular MCO Medicaid product, or either to not enroll, or to disenroll from, another MCO Medicaid product. Marketing does not include communication to a Medicaid beneficiary from the issuer of a qualified health plan, as defined in 45 CFR 155.20, about the qualified health plan.

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.

Mass Media – A method of public advertising that can create plan name recognition among a large number of Medicaid recipients and can assist in educating them about

potential health care choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, newsletters, and video in doctor's office waiting rooms.

Medicaid – The medical assistance Program authorized by Title XIX of the Social Security Act.

Medicaid Fraud Control Unit (MFCU) – 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.

Medicaid Management Information System (MMIS) – The MMIS is an integrated group of procedures and computer-processing operations (subsystems) developed at the general design level to meet principal objectives. For Title XIX purposes, "systems mechanization" and "mechanized claims processing and information retrieval systems" is identified in section 1903(a)(3) of the Act and defined in regulation at 42 CFR 433.111. The objectives of this system and its enhancements include the Title XIX program control and administrative costs; service to recipients, providers and inquiries; operations of claims control and computer capabilities; and management reporting for planning and control.

Medicaid Recipient Fraud Unit (MRFU) – The division of the State Attorney General's Office that is responsible for the investigation and prosecution of recipient fraud.

Medical Doctor (MD) – An individual physician must be licensed by the Board of Medical Examiners, under the South Carolina Department of Labor, Licensing and Regulations.

Medical Loss Ratio (MLR) – The proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio (MLR).

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 be multiple Medical Networks in a county.

Medical Necessity – Medically Necessary Services are those services utilized in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures.

Medicare – A federal health insurance Program for people 65 or older and certain individuals with disabilities.

Member or Medicaid Managed Care Member – An eligible person who is currently enrolled with a SCDHHS approved Medicaid Managed Care CONTRACTOR. Throughout this Contract, this term is used interchangeably with “Enrollee” and “Beneficiary”.

Member Incentive – Incentives to encourage a Medicaid Managed Care Member to change or modify behaviors or meet certain goals.

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.

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.

National Drug Code (NDC) – A unique 10-digit, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The segments identify the labeler or vendor, product (within the scope of the labeler), and trade package (of this product).

Newborn – A live child born to a member during her membership or otherwise eligible for voluntary enrollment under this Contract.

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 Medicaid 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.

Non-Participating Provider Physician – A physician licensed to practice who has not contracted with or is not employed by the CONTRACTOR to provide health care services.

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.

Outpatient Services – 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 twenty-four (24) hours.

Overpayment: The amount paid by the CONTRACTOR to a Provider, which is in excess of the amount that is allowable for services furnished under section 1902 of the Act, or to which the Provider is not entitled and which is required to be refunded under section 1903 of the Act.

Ownership Interest – The possession of equity in the capital, the stock or the profits of the entity. For further definition see 42 CFR 455.101 (2009 as amended).

Performance Improvement Projects (PIP) – Projects designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. In accordance with 42 CFR 438.240 the PIP must involve the following:

- Measurement of performance using objective quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

Physician – For the purposes of this Contract, a “Physician” is any of the following types of professionals that are legally authorized by the state to practice, regardless of whether they are Medicare, Medicaid, or Children's health Insurance Program (CHIP) providers:

- Doctors of medicine or osteopathy,
- Doctors of dental medicine or dental surgery,
- Doctors of podiatric medicine,
- Doctors of optometry,
- Chiropractors

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.

Prevalent Non-English Language – A non-English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

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

Primary Care Provider (PCP) – 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 approved services by the CONTRACTOR before rendered.

Procedure – For the purposes of this Contract, Procedure is defined as:

- An act or a manner of proceeding in an action or process;
- Any acceptable and appropriate mode of conducting all or a portion of work—the individual or collective tasks or activities.

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 protected health information as defined in 45 CFR §160.103.

Provider – In accordance with 42 CFR § 400.203 Definitions specific to Medicaid, any individual or entity furnishing Medicaid services under a provider agreement with the CONTRACTOR or the Medicaid agency. These may include the following:

- Any individual, group, physicians (such as but not limited includes Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Outpatient Center (free standing or owned) Clinics and Laboratories) furnishing Medicaid services under an agreement with the Medicaid agency; or
- For the Medicaid Managed Care Program, any individual, group, physicians (including but not limited to Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary providers, Clinics, Outpatient Centers (free standing or owned) and Laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.

Provider Dispute – Refers to a dispute between a Provider and the CONTRACTOR. Disputes may include, but will not be limited to:

- Lost or incomplete claim(s);
- Request(s) for additional explanation from the CONTRACTOR for service(s) or treatment(s) rendered by a Provider;
- Inappropriate or unapproved referral(s) initiated by Provider(s); or
- Any other reason for billing or non-billing related Disputes.

Provider Dispute System – Refers to a CONTRACTOR’s formal internal system for Providers to dispute the CONTRACTOR’s policies, procedures, or any aspect of the CONTRACTOR’s administrative functions.

Provider Incentives or Provider-Designated Incentives – Provider-designated incentives are those incentives paid by the CONTRACTOR to qualified Providers for achieving designated goals. Provider-designated incentives are paid for the programs listed in the Managed Care Policy and Procedure Guide.

Qualified Medicaid Provider – Any provider actively enrolled with SCDHHS.

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 Assessment and Performance Improvement (QAPI) – Activities aimed at improving in the quality of care provided to enrolled members through established quality management and performance improvement processes.

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

Quality Assurance Committee – A variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.) that represent a CONTRACTOR’s participating network of Providers—including representation from the CONTRACTOR’s management or Board of Directors—from a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.) with an emphasis on primary care, such as obstetrics and pediatrics.

Recipient – A person who is determined Eligible to receive services as provided for in the South Carolina State Plan for Medical Assistance.

Recoupment – The recovery by, or on behalf of, either the State Agency or the CONTRACTOR of any outstanding Medicaid debt.

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.

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

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. A RHC eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A RHC provides a wide range of primary care and enhanced services in a medically underserved area.

Service Area – The geographic area in which the CONTRACTOR is authorized to accept enrollment of eligible Medicaid Managed Care members into the CONTRACTOR's Health Plan. The service area must be approved by SCDOI.

Service Level Agreement (SLA) – A type of subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the CONTRACTOR specifically related to fulfilling the CONTRACTOR's obligations to the SCDHHS under the terms of this Contract.

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.

Significant Business Transactions – Any business transaction or series of transactions during any of the fiscal year that exceed the \$25,000 or five (5%) percent of the CONTRACTOR's total operating expenses.

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.

Social Security Administration (SSA) – An independent agency of the United States federal government that administers Social Security, a social insurance program consisting of retirement, disability, and survivors' benefits.

Social Services – Medical assistance, rehabilitation, and other services defined by Title XIX, and Department regulations.

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

Subcontract – A written agreement between the 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.

Subrogation – The right of the Department to stand in the place of the CONTRACTOR or client in the collection of third party resources.

Supplemental Security Income (SSI) – Benefits paid to pays benefits to disabled adults and children who have limited income and resources.

Suspension of Payment for Credible Allegation – In accordance with §42 CFR 455.23 Suspension of payment in cases of fraud, means that all Medicaid payments to a provider are suspended after the agency determines there is a credible allegation of fraud for which an investigation is pending under the Medicaid program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

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 Parties – Third parties are other individuals or entities, whether or not they operate in the United States.

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.

Third Party Resources – Any entity or funding source other than the Medicaid Managed Care Program member or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care provided to a Medicaid Managed Care Program member.

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 Oriented Contract (VOC) – Refers to:

- Payment methodology designed to cut waste and/or reflect value.
- Payments that cut waste are those that, by their design, reduce unnecessary payment and unnecessary care (e.g. elective cesarean deliveries).
- Payments that reflect value are those that are tied to provider performance and may rise or fall in a predetermined fashion commensurate with different levels of performance assessed against standard measures.

Waste – The unintentional misuse of Medicaid funds through inadvertent error that most frequently occurs as incorrect coding and billing.

Withhold – A percentage of payments or set dollar amount that an organization deducts for a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on the specific predetermined factors.

APPENDIX 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

Broker: LogistiCare	Broker: LogistiCare	Broker: LogistiCare
<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>