SOUTH CAROLINA
Healthy Connections
MEDICAID

POLICY and PROCEDURE GUIDE
For
MANAGED CARE ORGANIZATIONS

July 1, 2018

INTRODUCTION 1
REQUIREMENTS FOR CERTIFICATION AS A MCO 2
THE CONTRACT PROCESS 2
1.0 GENERAL PROVISIONS 4
2.0 CONTRACTOR ADMINISTRATIVE REQUIREMENTS 5
2.1 GENERAL ADMINISTRATIVE REQUIREMENTS 5
2.2 STAFFING REQUIREMENTS 5
2.3 TRAINING REQUIREMENTS 5
2.4 LICENSING REQUIREMENTS 5
2.5 SUBCONTRACTING AND DELEGATION OF AUTHORITY 5
2.6 SUBCONTRACT BOILERPLATE REQUIREMENTS 6
2.7 PROVIDER SUBCONTRACT REQUIREMENTS 6
2.8 PROVIDER ENROLLMENT AND CREDENTIALING 6
3.0 MEMBER ELIGIBILITY AND ENROLLMENT 11
3.1 MEMBER ELIGIBILITY 11
3.2 MEMBER ELIGIBILITY REDETERMINATION 12
3.3 MEMBER ENROLLMENT 14
3.4 MEMBER ENROLLMENT PROCESS 14
3.5 MEMBER ENROLLMENT EFFECTIVE DATE 16
3.6 MEMBER ANNUAL RE-ENROLLMENT OFFER 16
3.7 SPECIAL RULES FOR THE ENROLLMENT OF NEWBORNS 16
3.8 SPECIAL RULES FOR ENROLLMENT OF AMERICAN INDIANS 19
3.9 RE-ENROLLMENT 19
3.10 MAXIMUM MEMBER ENROLLMENT 20
3.11 SUSPENSION AND/OR DISCONTINUATION OF ENROLLMENT 20
3.12 MEMBER DISENROLLMENT 20
3.13 MEMBER ENROLLMENT INFORMATION AND MATERIALS REQUIREMENTS 20
3.14 MEMBER EDUCATION 21
3.15 MEMBER COMMUNICATION 21
3.16 MEMBER RIGHTS 22
3.17 MEMBER RESPONSIBILITIES 22
3.18 MEMBER CALL CENTER 22
4.0 CORE BENEFITS AND SERVICES 23
4.1 GENERAL CORE BENEFITS AND SERVICES REQUIREMENTS 23
4.2 SPECIFIC CORE BENEFITS AND SERVICE REQUIREMENTS 23
4.3 ADDITIONAL SERVICES 41
4.4 EXCLUDED SERVICES 42
4.5 MEDICAL NECESSITY DETERMINATION 46

4.6 OUT-OF-NETWORK COVERAGE 46
4.7 SECOND OPINIONS 46
4.8 MEMBER INCENTIVES 46
4.9 MORAL AND RELIGIOUS OBJECTION 46
5.0 CARE MANAGEMENT AND COORDINATION 48
5.1 GENERAL CARE MANAGEMENT AND COORDINATION REQUIREMENTS 48
5.2 NATIONAL STANDARDS REQUIREMENTS 48
5.3 MEMBER RISK STRATIFICATION REQUIREMENTS 48
5.4 MEMBER RISK AND CARE MANAGEMENT ACTIVITY REQUIREMENTS 48
5.5 CONTINUITY OF CARE MANAGEMENT ACTIVITIES 48
6.0 NETWORKS (PROVIDER NETWORK REQUIREMENTS) 51
6.1 GENERAL MEDICAID MANAGED CARE NETWORK REQUIREMENTS 51
6.2 CONTRACTOR PROVIDER NETWORK 51
6.3 PROVIDER NETWORK SUBMISSION 63
7.0 PAYMENTS 65
7.1 FINANCIAL MANAGEMENT 65
7.2 MEDICAL LOSS RATIO (MLR) 65
7.3 CAPITATION PAYMENTS FROM THE DEPARTMENT TO CONTRACTOR 65
7.4 PAYMENTS FROM CONTRACTOR TO SUBCONTRACTORS 70
7.5 COPAYMENTS 76
7.6 EMERGENCY SERVICES 77
7.7 PAYMENT STANDARDS 77
7.8 PROHIBITED PAYMENTS 78
7.9 PERIODIC AND ANNUAL AUDITS 78
7.10 RETURN OF FUNDS 78
7.11 MEDICAID PROVIDER TAX RETURNS 78
8.0 UTILIZATION MANAGEMENT 79
8.1 GENERAL REQUIREMENTS 79
8.2 CONTRACTOR UTILIZATION MANAGEMENT (UM) PROGRAM REQUIREMENTS 79
8.3 CONTRACTOR UTILIZATION MANAGEMENT (UM) PROGRAM REPORTING REQUIREMENTS 79
8.4 PRACTICE GUIDELINES 79
8.5 SERVICE AUTHORIZATION 79
8.6 TIMEFRAME OF SERVICE AUTHORIZATION DECISIONS 79
8.7 EXCEPTIONS TO SERVICE AUTHORIZATION REQUIREMENTS 79
8.8 EMERGENCY SERVICE UTILIZATION 79
8.9 OUT-OF-NETWORK USE OF NON-EMERGENCY SERVICES 79
9.0 GRIEVANCE AND APPEALS PROCEDURES AND PROVIDER DISPUTES 80
9.1 MEMBER GRIEVANCE AND APPEAL SYSTEM 80

9.2 PROVIDER DISPUTE SYSTEM 82
10.0 THIRD PARTY LIABILITY 83
10.1 GENERAL 83
10.2 DEPARTMENTAL RESPONSIBILITIES 83
10.3 CONTRACTOR RESPONSIBILITIES 84
10.4 COST AVOIDANCE 84
10.5 POST PAYMENT RECOVERIES (BENEFIT RECOVERY ACTIVITIES) 85
10.6 RETROACTIVE ELIGIBILITY FOR MEDICARE 87
10.7 THIRD PARTY LIABILITY REPORTING DISENROLLMENT REQUESTS 87
10.8 THIRD PARTY LIABILITY RECOVERIES BY THE DEPARTMENT 87
10.9 REPORTING REQUIREMENTS 87
11.0 PROGRAM INTEGRITY 90
11.1 GENERAL REQUIREMENTS 90
11.2 COMPLIANCE PLAN REQUIREMENTS 102
11.3 CONTRACTOR'S CONTROLS 103
11.4 REVIEWS, INVESTIGATIONS AND AUDITS 104
11.5 REFERRAL COORDINATION AND COOPERATION 106
11.6 OVERPAYMENTS, RECOVERIES, AND REFUNDS 106
11.7 COOPERATION AND SUPPORT IN INVESTIGATIONS, HEARINGS, AND DISPUTES 107
11.8 SUSPENSION OF PAYMENT BASED ON CREDIBLE ALLEGATION OF FRAUD 107
11.9 PREPAYMENT REVIEW 107
11.10 STATEWIDE PHARMACY LOCK-IN PROGRAM (SPLIP) 108
11.11 OWNERSHIP AND CONTROL 118
11.12 CONTRACTOR PROVIDERS AND EMPLOYEES – EXCLUSIONS, DEBARMENT, AND TERMINATIONS 119
11.13 PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES 120
11.14 PROVIDER TERMINATION / DENIAL OF CREDENTIALS 121
11.15 INFORMATION RELATED TO BUSINESS TRANSACTIONS 121
11.16 INFORMATION ON PERSONS CONVICTED OF CRIMES 121
12.0 MARKETING PROGRAM 122
12.1 GENERAL MARKETING REQUIREMENTS 122
12.2 GUIDELINES FOR MARKETING MATERIALS AND ACTIVITIES 122
12.3 MARKETING PLAN REQUIREMENTS 123
12.4 MARKETING MATERIAL SUBMISSION REQUIREMENTS 126
12.5 MARKETING MATERIAL DISTRIBUTION AND PUBLICATION STANDARDS AND REQUIREMENTS 127
13.0 REPORTING REQUIREMENTS 128
13.1 GENERAL REQUIREMENTS 128
14.0 ENCOUNTER DATA, REPORTING AND SUBMISSION REQUIREMENTS 135

14.1 GENERAL DATA REQUIREMENTS 135
14.2 MEMBER DATA 135
14.3 CLAIMS DATA 135
14.4 ELECTRONIC TRANSACTIONS 135
14.5 ENCOUNTER DATA 135
14.6 SUBMISSION OF TEST ENCOUNTER DATA 137
14.7 ELIGIBILITY AND ENROLLMENT EXCHANGE REQUIREMENTS 137
14.8 FQHC / RHC ENCOUNTER REPORTING 137
14.9 ERRORS AND ENCOUNTER VALIDATION 143
14.10 DATA VALIDATION 143
14.11 SYSTEM AND INFORMATION SECURITY AND ACCESS MANAGEMENT REQUIREMENTS 144
14.12 SUBCONTRACTOR(S) AND ENCOUNTER DATA REPORTING 145
14.13 PERIODIC AUDITS 145
14.14 FUTURE ENCOUNTER DATA REPORTING REQUIREMENTS 145
15.0 QUALITY MANAGEMENT AND PERFORMANCE 146
15.1 GENERAL REQUIREMENTS 146
15.2 QUALITY ASSURANCE COMMITTEE 146
15.3 MEMBER SATISFACTION SURVEY 146
15.4 QUALITY PERFORMANCE MEASURES 147
15.5 QUALITY WITHHOLD AND BONUS PROGRAM 148
15.6 ALTERNATIVE PAYMENT MODELS (APM) 151
15.7 NCQA ACCREDITATION STANDARDS AND REQUIREMENTS 152
15.8 EXTERNAL QUALITY REVIEW (EQR) 152
15.9 PROVIDER PREVENTABLE CONDITIONS 156
16.0 DEPARTMENT'S RESPONSIBILITIES 157
16.1 DEPARTMENT CONTRACT MANAGEMENT 157
16.2 PAYMENT OF CAPITATED RATE 157
16.3 NOTIFICATION OF MEDICAID MCO PROGRAM POLICIES AND PROCEDURES 157
16.4 QUALITY ASSESSMENT AND MONITORING ACTIVITIES 157
16.5 FEE-FOR-SERVICE (FFS) REPORTING TO MCOS 157
16.6 REQUEST FOR PLAN OF CORRECTION 157
16.7 EXTERNAL QUALITY REVIEW 157
16.8 MARKETING 158
16.9 GRIEVANCES / APPEALS 158
16.10 TRAINING 158
17.0 TERMINATION AND AMENDMENTS 159
17.1 TERMINATION UNDER MUTUAL AGREEMENT 159
17.2 TERMINATION BY DEPARTMENT FOR BREACH 159

17.3 TERMINATION FOR UNAVAILABILITY OF FUNDS 159
17.4 TERMINATION FOR CONTRACTOR INSOLVENCY, BANKRUPTCY, INSTABILITY OF FUNDS 159
17.5 TERMINATION BY THE CONTRACTOR 159
17.6 TERMINATION FOR LOSS OF LICENSURE OR CERTIFICATION 159
17.7 TERMINATION FOR NONCOMPLIANCE WITH THE DRUG FREE WORKPLACE ACT 159
17.8 TERMINATION FOR ACTIONS OF OWNERS / MANAGERS 159
17.9 NON-RENEWAL 159
17.10 TERMINATION PROCESS 160
17.11 AMENDMENTS AND RATE ADJUSTMENTS 160
18.0 AUDITS, FINES AND LIQUIDATED DAMAGES 161
18.1 AUDIT 161
18.2 LIQUIDATED DAMAGES FOR FAILURE TO MEET CONTRACT REQUIREMENTS 161
18.3 CORRECTIVE ACTION PLAN 161
18.4 SANCTIONS 161
18.5 PLAN OF CORRECTION REQUIRED (CONTRACT NON-COMPLIANCE) 165
19.0 TERMS AND CONDITIONS 166
19.1 GENERAL CONTRACTUAL CONDITION 166
19.2 HIPAA COMPLIANCE 166
19.3 HIPAA BUSINESS ASSOCIATE 166
19.4 SAFEGUARDING INFORMATION 166
19.5 RELEASE OF RECORDS 166
19.6 CONFIDENTIALITY OF INFORMATION 166
19.7 INTEGRATION 166
19.8 HOLD HARMLESS 166
19.9 HOLD HARMLESS AS TO THE MEDICAID MANAGED CARE PROGRAM MEMBERS 166
19.10 NOTIFICATION OF LEGAL ACTION 166
19.11 NON-DISCRIMINATION 167
19.12 SAFETY PRECAUTIONS 167
19.13 LOSS OF FEDERAL FINANCIAL PARTICIPATION 167
19.14 SHARING OF INFORMATION 167
19.15 APPLICABLE LAWS AND REGULATIONS 167
19.16 INDEPENDENT CONTRACTOR 167
19.17 GOVERNING LAW AND PLACE OF SUIT 167
19.18 SEVERABILITY 167
19.19 COPYRIGHTS 167
19.20 SUBSEQUENT CONDITIONS 167
19.21 INCORPORATION OF SCHEDULES / APPENDICES 167
19.22 TITLES 168

19.23 POLITICAL ACTIVITY 168
19.24 FORCE MAJEURE 168
19.25 CONFLICT OF INTEREST 168
19.26 DEPARTMENT POLICIES AND PROCEDURES 168
19.27 STATE AND FEDERAL LAW 168
19.28 CONTRACTOR'S APPEAL RIGHTS 168
19.29 COLLUSION / ANTI-TRUST 168
19.30 INSPECTION OF RECORDS 168
19.31 NON-WAIVER OF BREACH 168
19.32 NON-ASSIGNABILITY 168
19.33 LEGAL SERVICES 169
19.34 ATTORNEY'S FEES 169
19.35 RETENTION OF RECORDS 169
DEFINITION OF TERMS 170
APPENDIX 1 — MEMBERS' AND POTENTIAL MEMBERS' BILL OF RIGHTS 193
APPENDIX 2 — PROVIDERS' BILL OF RIGHTS 195
APPENDIX 3 — TRANSPORTATION BROKER LISTING AND CONTACT INFORMATION 196

MANAGED CARE ORGANIZATION PROGRAMS

The purpose of this guide is to document the medical and Program Policies and requirements implemented by the South Carolina Department of Health and Human Services (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 is a priority/goal of the SCDHHS. 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" twenty four (24) hours a day, seven (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 Division of Managed Care 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 Division of Managed Care at the following address:

Division of Managed Care
Department of Health and Human Services
PO Box 8206
Columbia, SC 29202-8206

Requests to add, modify, or delete standards, criteria, or requirements related to current medical or Program Policy should be forwarded to the Division of Managed Care.

REQUIREMENTS FOR CERTIFICATION AS A MCO

THE CONTRACT PROCESS

A copy of the model MCO contract can be found on the SCDHHS website 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 website, www.doi.sc.gov. The SCDHHS Division of Managed Care 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 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 Personnel. 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, SCDHHS or its contracted agent(s) will review Service Area networks submitted by the prospective 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 boilerplate 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 Managed Care Report Companion Guide housed on the SCDHHS website 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.

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.

Section 2.1.9.1 through Section 2.1.9.2: The MCO must submit an organizational chart annually and upon any changes to Key Personnel. Annual submissions are due by September thirtieth (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 Division of Managed Care account liaison.

2.2 Staffing Requirements

Section 2.2.1.1 through Section 2.2.1.2: 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 Personnel 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 Division of Managed Care account liaison. No response from the department within ten (10) Business 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 other requirements.

2.3 Training Requirements

For all cites in Section 2.3 through Section 2.3.1.3, please refer to the contract for all requirements.

2.4 Licensing Requirements

For all cites in Section 2.4 through Section 2.4.3.2, please refer to the contract for all requirements.

2.5 Subcontracting and Delegation of Authority

For all cites in Section 2.5 through Section 2.5.16, please refer to the contract for all requirements.

2.6 Subcontract Boilerplate Requirements

For all cites in Section 2.6.1, please refer to the contract for all requirements.

Section 2.6.2 through 2.6.2.2: 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., South Carolina Healthy Connections Medicaid)
- 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.

2.7 Provider Subcontract Requirements

For all cites in Section 2.7 through Section 2.7.1, please refer to the contract for all requirements.

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.

Section 2.8.2.4 through Section 2.8.2.5.3: 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 (re-Credentialing) application, and to a non-discriminatory review and receive notification of these rights.

The MCO may delegate the Credentialing and/or re-Credentialing process in accordance with the SCDHHS contract and NCQA Credentialing standards. MCOs are held accountable for ensuring delegated entities follow the requirements in accordance with the 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 Benefits and Additional Services as offered by the MCO.

Whether the MCO does the initial Credentialing/re-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 any Centers for Medicare and Medicaid Services (CMS) sanction reports, 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 by the laboratory.
- 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.
- 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.
- Alcohol and Substance Abuse clinics must be licensed by DHEC.
- Portable x-ray Providers must be surveyed by DHEC and certified by CMS.
- Stationary x-ray equipment must be registered with DHEC.
- 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 must Credential the State agency/organization rather than each individual Provider employed at the agency/organization.

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

Medicaid MCOs may utilize Nurse Practitioners (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).

   <u>MCOs must:</u>

   - 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.

   <u>MCOs must:</u>

   - 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 the Provider file to the Enrollment broker must be coded to allow

Member choice only.

For all cites in Section 2.8.3 through Section 2.8.3.3, please refer to the contract for all requirements.

3.0 Member Eligibility and Enrollment

3.1 Member Eligibility

Section 3.1: The 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 eligibility category
- Are not participating in a Home and Community Based waiver Program
- Are not participating in Hospice
- Are not participating in the Program for All Inclusive Care (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)
81	SSI w/Essential Spouse (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)
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

Section 3.2: A file of Members that will lose South Carolina Healthy Connections Medicaid eligibility is created monthly from the SCDHHS Member eligibility systems. These files reflect those Members whose Medicaid eligibility is due to end.

There are two files produced for Redetermination and posted to the MCO's EDI box:

1. **MEDS File:** &<hlq>.vendor-ID.REVIEW.FILE and &<hlq>.vendor-D.REVIEW.FILE.MCF
2. **CURAMFile:** &<hlq>.vendor-ID.REVIEW**C**.FILE and &<hlq>.vendor-ID.REVIEW**C**.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 with the Members found on these files 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.
- If SCDHHS has approved the message content, 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 utilizing the text messaging option MCOs may send one initial opt in text message to members annually.
- MCOs can notify Primary Care Providers that a patient needs to renew their Medicaid eligibility.

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. This process is intended to encourage the Member to regain their South Carolina Healthy Connections Medicaid 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 Disenrolled 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.

3.4 Member Enrollment Process

Section 3.4: 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 annual Enrollment period. After the ninety (90) Day choice period has expired, Medicaid MCO Members must remain in their Health Plan until their annual 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.

Member Enrollment Process (Non-Newborns)

Section 3.4.1 through Section 3.4.4: 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 this guide) 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. Effective with enrollments beginning October, 1 2019, Members that do not choose an MCO, but either (1) have immediate family members Enrolled with an MCO or (2) have been previously Enrolled with an MCO in the past seventy five (75) to ninety days (90) (three (3) Enrollment periods), will be assigned to that MCO if available in the Beneficiary's county of residence.

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 zero (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.

3.5 Member Enrollment Effective Date

For all cites in Section 3.5 through Section 3.5.2, please refer to the contract for all requirements.

3.6 Member Annual Re-Enrollment Offer

For all cites in Section 3.7 through Section 3.7.2, please refer to the contract for all requirements.

3.7 Special Rules for the Enrollment of Newborns

Linked Newborn Enrollment – Retrospective:

Section 3.7 through Section 3.7.2: 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 (3) 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 automated maternity kicker payment calculated as part of the monthly automated/systemic Capitation Payment process utilizing the premium rate cells MG2 and NG2 provided the mother and child are linked to one another during the eligibility enrollment 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 report* found in the Managed Care 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 delivery. The table 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 report will be returned to the MCO upon processing of the requests. Any payments made will be indicated on the report.

In order to be processed as a manual maternity kicker for Newborns and stillborn births, the form must be completed as follows:

1. In months one(1) through five (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 Stillborn births: 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 six (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 six (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 six (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

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

3.8 Special Rules for Enrollment of American Indians

For all cites in Section 3.8, please refer to the contract for all requirements.

3.9 Re-enrollment

Section 3.9: 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 in the Medicaid MCO Member's managed care 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.

3.10 Maximum Member Enrollment

Section 3.10 through Section 3.10.1: SCDHHS will suspend additional affected managed care Enrollments for any MCO whose enrollment percentage reaches fifty percent or more (>50%) of the total statewide managed care population. The suspension of affected Enrollments shall be for a six month period for any MCO meeting this condition. The MCO will not be allowed additional affected Enrollments until its percentage of total statewide membership is less than fifty percent (<50%) of the statewide managed care population at the end of any six month evaluation period.

3.11 Suspension and/or Discontinuation of Enrollment

For all cites in Section 3.11 through Section 3.11.3.3, please refer to the contract for all requirements.

3.12 Member Disenrollment

Section 3.12.1 through Section 3.12.2.7: 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 in this guide).

3.13 Member Enrollment Information and Materials Requirements

For all cites in Section 3.13.1 through Section 3.13.4.9, please refer to the contract for all requirements.

Section 3.13.5 through Section 3.13.5.10: Each month the MCO must provide a full Provider directory to the Enrollment broker. The format for the Provider directory may be found on the SCDHHS website in the Report Templates section under Additional Resources.

3.14 Member Education

For all cites in Section 3.14 through Section 3.14.10, please refer to the contract for all requirements.

3.15 Member Communication

For all cites in Section 3.15.1 through Section 3.15.1.5, please refer to the contract for all requirements.

Section 3.15.1.2 through Section 3.15.2.10.1: New or revised Member materials must 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 (Healthy Blue by BlueChoice), 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 3.15.3 through Section 3.15.4, please refer to the contract for all requirements.

3.16 Member Rights

For all cites in Section 3.16.1, please refer to the contract.

Section 3.16.2:. 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 MCO will provide the Member the following information and ensure the member rights and responsibilities outlined in the contract.

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

Appendix 1 of this guide provides MCO's with a Member rights and responsibility document that may be shared with Members and potential Members.

For all cites in Section 3.16.3 through Section 3.16.4.5.1, please refer to the contract.

3.17 Member Responsibilities

For all cites in Section 3.17 through Section 3.17.7, please refer to the contract.

3.18 Member Call Center

For all cites in Section 3.18 through Section 3.18.16.13, please refer to the contract for all requirements.

Section 3.18.17 through Section 3.18.17.11: 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 4.1.7: 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/.

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 Medicaid Fee-for-Service (FFS) 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

Section 4.2.1 through Section 4.2.1.3: 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 deny payment until proper completion and submission of the form(s).

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 women suffers a life-endangering condition that would place the women in danger of death unless an abortion

is performed and must be documented in the Health 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 Health 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

Section 4.2.2. through Section 4.2.2.1: 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 Service 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

Section 4.2.3 through Section 4.2.3.1: 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 with the Provider(s) of these services. Prior Authorization for these services shall not be required of either network or Non-Participating Providers.

4.2.4 Audiological Services

Section 4.2.4 through Section 4.2.4.2: A referral occurs when the Physician or other licensed practitioner of the healing arts 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

Section 4.2.5 through Section 4.2.5.2: MCO's are responsible for the full array of Behavioral Health Services set forth in the following manuals:

- Autism Spectrum Disorder Provider manual

- Hospital Services Provider manual
- Licensed Independent Practitioner's Provider manual
- Psychiatric Residential Treatment Services located in the Psychiatric Hospital Services Provider manual
- Clinic Services manual
- Physicians, Laboratories, and Other Medical Professionals Provider manual
- Rehabilitative Behavioral Health Services Provider manual
- Community Mental Health Clinics

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 psycho-educational service Providers (qualified and preforming 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 4.2.5.3, please refer to the contract for all requirements.

Section 4.2.5.4 through 4.2.5.4.1: For any member aged twenty one (21) through sixty four (64) receiving inpatient treatment in an Institution for Mental Disease (IMD) the length of stay must not exceed 15 days in any calendar month. SCDHHS will prorate the member(s) premium(s) for any calendar month where an IMD stay was in excess of fifteen (15) days. The proration process will occur at least annually after SCDHHS and its actuary have analyzed encounter data for any instances where stays exceed fifteen (15) days. A template of the report may be found in the Reports Companion Guide..

Section 4.2.5.5: The MCO is responsible for submitting the following monthly Autism and Psychiatric Residential Treatment Facility (PRTF) reports.

1. PRTF Claim payment report
2. PRTF Prior Authorization report
3. Autism Claim payment report
4. Autism Prior Authorization report

The report templates can be viewed in the Managed Care Report Companion Guide and accessed at the following link: https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates.

For all cites in Section 4.2.6 through Section 4.2.8.1, please refer to the contract for all requirements.

4.2.9 Durable Medical Equipment (DME)

Section 4.2.9 through Section 4.2.9.1: 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 4.2.11.2.8.4, **p**lease refer to the contract for all requirements .

4.2.12 Family Planning Services

Section 4.2.12 through Section 4.2.12.3: 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 Members 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 of Family Planning Services.

Detailed Policy information regarding Family Planning Services 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 cites in Section 4.2.13, please refer to the contract for all requirements.

4.2.14 Hysterectomies

Section 4.2.14 through Section 14.2.14.2: 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 form instructions. The original form must be maintained in the Medicaid MCO Member's Health Record and a copy must be submitted to the MCO for retention in the event of audit. In the event the requesting Physician does not complete and submit the required forms, it is permissible for the MCO to delay or deny payment until proper completion and submission of the form(s).

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

Section 14.2.15 through Section 4.2.15.1: Benefits cover Medically Necessary laboratory and x-ray services, including genetic testing services ordered by a Physician and provided by independent laboratories and portable and free standing 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 independent laboratories. MCOs are responsible for reimbursement to these State based independent laboratory Providers. State based laboratories 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, 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

Section 4.2.16 through Section 4.2.16.1: 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 Redeteremination re-establishes Medicaid eligibility and 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 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 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)

For all cites in Section 4.2.17 through Section 4.2.17.4, please refer to the contract.

Section 4.2.17.5: Administrative Days are counted as part of the hospital stay and **do not** count towards fulfilling the MCO long-term care responsibility.

Hospital 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

Section 4.2.18 through Section 4.2.18.3: 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

For all cites in Section 4.2.19, please refer to the contract.

Section 4.219 through Section 4.2.19.1: 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 for Medicaid Eligible children infected with Human Immunodeficiency Virus (HIV). 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 the children of women that have been exposed to 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 HIV exposed children will be followed with frequent clinical and laboratory evaluations to allow early identification of those children who are infected with the virus.
- 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.
- 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. These evaluations 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 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 Care Coordination and social work services to affected families, assisting them with specialty and Primary Care Service follow-up 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

Section 4.2.20 through Section 4.2.20.2: 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 at https://www.scdhhs.gov/.

4.2.21 Pharmacy / Prescription Drugs

For all cites in Section 4.2.21, please refer to the contract for all requirements.

Section 4.2.21.1: Medications for the treatment of Hepatitis C Virus (HCV) are carved-out of the South Carolina Medicaid Managed Care Organization (MCO) pharmacy Benefit. HCV medications are provided to MCO beneficiaries through the Fee-for-Service (FFS) Medicaid 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 deny 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 4.2.21.2 through Section 4.2.21.2.5, please refer to the contract for all requirements.

Section 4.2.21.3 through Section 4.2.21.3.3: 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(PA) under the new Plan's formulary for a period up to ninety (90) Days.

MCOs are required to support the universal PA medication form for all medications except for the following medications.

- Synagsis
- 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.

Neither Prior Authorization, nor a call, is required for the emergency three (3) Day supply. Dispensing fees may be charged on both the three (3) Day supply and when the balance of the prescription is filled by the pharmacy. Copayments are not allowed on the three (3) 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/.

Medication Assisted Therapy (MAT) Minimum Coverage Criteria:

The use of less restrictive parameters and the approval of therapy for a period longer than indicated in this document are permissible. MCOs retain the flexibility to require that specific medications be delivered through a particular benefit (e.g., medical or pharmacy) or to require the use of a particular specialty pharmacy.

Oral Buprenorphine

Buprenorphine/Naloxone

- Generic oral formulations of buprenorphine/naloxone, as well as the sublingual film formulation (*Suboxone® Sublingual Film*), are covered without prior authorization for doses up to a daily dose of 24 mg of buprenorphine.
    - MCOs may require authorization for members under the age of 16.
- Retrospective analyses and reviews may be used to ensure that members meet DSM 5 criteria for moderate or severe opioid use disorder.
- To ensure access for members looking to initiate MAT, MCOs must allow at least a three-day initial supply for non-preferred buprenorphine/naloxone formulations.

Buprenorphine monotherapy

- Buprenorphine monotherapy requires prior authorization and is covered only for pregnant women or members with a documented allergy to naloxone. Plans may grandfather members currently on therapy, and plans must take the necessary steps to ensure an adequate transition of therapy for members currently on buprenorphine monotherapy.
    - When practical, plans are encouraged to adopt electronic means of verifying pregnancy through the electronic claims processing system, rather than relying on the need for telephonic or paper-based PA processes.
- After delivery, members must be transitioned to a buprenorphine/naloxone combination product.

Subcutaneous Buprenorphine

Subcutaneous buprenorphine must be available without requirements for step therapy. MCOs may ensure that the following conditions are met prior to payment for subcutaneous buprenorphine:

- Diagnosis of moderate to severe opioid use disorder
- No concomitant use of opioid medications
- Initiation with a transmucosal or oral buprenorphine containing product at a dose of 8-24 mg of buprenorphine daily for at least seven (7) days

- No use of supplemental oral, sublingual, or transmucosal buprenorphine
- Dosing consistent with FDA labeling

Initial authorization must be for a period of at least six (6) months. Criteria for approval for continuation may include the requirements listed above.

Subdermal Buprenorphine Implant

MCOs may require prior authorization for buprenorphine subdermal implant. Criteria may include the following:

- Achieved and sustained prolonged clinical stability on transmucosal buprenorphine
- Currently maintained on a dose of 8 mg per day or less of oral, sublingual, or transmucosal buprenorphine product equivalent
- Stable on oral, sublingual, or transmucosal buprenorphine dose for six (6) months or longer without any need for supplemental dosing or adjustments
- Prescriber and/or the healthcare provider performing insertion has successfully completed a live training program specific to Probuphine insertion, as required by the product's manufacturer

After one (1) insertion in each arm, most members should be transitioned back to a transmucosal buprenorphine-containing product, if continued treatment is necessary. Neither re-insertion into previously-used administration sites, nor into sites other than the upper arm, has been studied. As such, therapy should generally be limited to twelve (12) months.

Extended-Release Intramuscular Naltrexone

Extended-release injectable naltrexone shall be provided without prior authorization. Step therapy parameters that require the use of oral naltrexone, methadone, or any formulations of buprenorphine or buprenorphine/naloxone combination therapies prior to receiving extended-release injectable naltrexone are not permitted except as otherwise indicated per package insert.

Tobacco Cessation Coverage:

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.

Section 4.2.21.4: Updates to an MCO's formulary must be provided to Medicaid MCO Members and Providers in a timely manner. The formulary must allow for coverage of any non-formulary products currently reimbursable as Fee-for-Service Medicaid by South Carolina Medicaid. Information regarding coverage allowance for non-formulary products must be disseminated to Medicaid MCO Members and Providers.

For all cites in Section 4.2.21.5 through Section 4.2.21.7, please refer to the contract for all requirements.

Section 4.2.21.8: The MCO must have in place claims review limitations as described in Section 1902(oo)(1)(A)(i)(I)&(II) of the SSA and a claims review automated process as described in Section 1902(oo)(1)(A)(i)(III) of the SSA. Pursuant to Section 1932(i) of the SSA, the Contractor must be in compliance with the applicable provisions of 42 CFR § 438.3(s)(2), 42 CFR § 438.3(s)(4), and 42 CFR § 438.3(s)(5), as such provisions were in effect on March 31, 2018.

For all cites in Section 4.2.21.9, please refer to the contract for all requirements.

4.2.22 Rehabilitative Therapies for Children – Non-Hospital Based

For all cites in Section 4.2.22 through Section 4.2.22.1, please refer to the contract for all requirements.

Section 4.2.22.2: MCOs are responsible for private Providers that are not providing services under contract with Local Education Authorities (LEA). The specific services and 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.

4.2.23 Substance Abuse

Section 4.2.23 through Section 4.2.23.3, please refer to the contract for all requirements.

Section 4.2.23.4: 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.

Alcohol and Other Drug (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 two (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 to 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 and encouraged to utilize the commissions for more than just substance abuse related services.

4.2.24 Transplant and Transplant-Related Services

Section 4.2.24 through Section 4.2.24.5:

Group I – Kidney and Corneal:

Kidney: The MCO is responsible for notifying their SCDHHS Program liaison of an impending transplant Case and working with the Program liaison 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 corneal transplants.

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 South Carolina Healthy Connections Choices Medicaid. Additionally, the MCO is responsible for all services prior to seventy-two (72) hours pre-admission, and all post-transplant services upon discharge, and all 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) and the event (hospital admission through discharge). The MCO is responsible for post discharge services rendered to a transplant recipient.

For all cites in Section 4.2.25, please refer to the contract for all requirements.

4.2.26 Sterilization

Section 4.2.26 through Section 4.2.26.2: 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 form instructions. The original form must be maintained in the Medicaid MCO Member's Health Record 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 deny payment until proper completion and submission of the form(s).

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 4.2.27 through Section 4.2.27.1, please refer to the contract for all requirements.

4.3 Additional Services

For all cites in Section 4.3. through Section 4.3.1, please refer to the contract for all requirements.

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 request must include the following data points: 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 Additional Service, the population being targeted and the Additional Service discontinuation criteria.

Please see the current Managed Care Report Companion Guide for the Additional Services request form report format for requesting Additional Services.

Additional Services 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.

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.

4.4 Excluded Services

For all cites in Section 4.4 through Section 4.4.1, please refer to the contract for all requirements.

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 Medicaid Fee-for-Service. MCOs are expected to be responsible for the Continuity of Care for all Medicaid MCO Members by ensuring appropriate Service Referrals are made for the Medicaid MCO Member for Excluded Services.

Medical (Non-Ambulance) Transportation

Medical non-ambulance transportation is defined as transportation of the Beneficiary to and/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 transportation broker system as part of its Care Coordination responsibilities, as detailed below. See Appendix 3 for transportation 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 broker(s))
- 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.

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 a managed care Core Benefit. As described above in the Covered Services Section, the facility charge for dental services provided in ambulatory surgical centers and operating rooms remain part of the managed care Core Benefit. The dental broker maintains responsibility for the determination of Medical Necessity for the use of such facilities and the MCO must comply with their determination and pay facility fees for approved services. The facility is responsible for providing the authorization for care in the facility to the MCO.

Targeted Case Management (TCM) Services

Targeted Case Management (TCM) consists of services that assist an individual Eligible

under the State Plan in gaining access to needed medical, social, educational, and other services. TCM services are available for Recipients with the following conditions: Alcohol and substance abuse, children in foster care, chronically mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with an intellectual disability 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 agencies:

- 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 the treatment of substance abuse and/or their dependents
- Department of Juvenile Justice: Services for children ages zero (0) to twenty one (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 zero (0) to twenty one (21) years in the custody of DSS and placed in foster care, and adults eighteen (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 zero (0) to twenty one (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 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 include Early Intervention Care Coordination and Family 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
- Children with complex medical needs
- Persons who are head or spinal cord injured

Home- and Community-Based waiver Beneficiaries must meet all medical and financial eligibility requirements to enroll in a waiver Program. A Plan of Care is developed along with the service needs by a Case Manager for all waiver Beneficiaries.

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 zero (0) to twenty-one (21) years of age. DEC services are provided 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 through Section 4.5.6, please refer to the contract for all requirements.

4.6 Out-of-Network Coverage

For all cites in Section 4.6 through Section 4.6.1, please refer to the contract for all requirements.

4.7 Second Opinions

For all cites in Section 4.7 through Section 4.7.3, please refer to the contract for all requirements.

4.8 Member Incentives

For all cites in Section 4.8, please refer to the contract for all requirements.

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 Managed Care 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 incentives.

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

4.9 Moral and Religious Objection

For all cites in Section 4.9 through Section 4.9.7, please refer to the contract for all requirements.

5.0 Care Management and Coordination

5.1 General Care Management and Coordination Requirements

For all cites in Section 5.1 through Section 5.1.4.3, please refer to the contract for all requirements.

5.2 National Standards Requirements

For all cites in Section 5.2 through Section 5.2.1.12, please refer to the contract for all requirements.

5.3 Member Risk Stratification Requirements

For all cites in Section 5.3 through Section 5.3.3, please refer to the contract for all requirements.

5.4 Member Risk and Care Management Activity Requirements

For all cites in Section 5.4 through Section 5.4.5, please refer to the contract for all requirements.

Section 5.4.5.1: The MCO must submit a monthly report of all Members that are receiving Care Management services. The MCO must submit this report to its SharePoint monthly library by the fifteenth (15th) of each month. The submitted report must include the methodology for risk stratification (i.e., CRG, DxCG or internal, if internal please describe and identify the tool), the risk score, risk level (low, moderate or high), Members Medicaid ID, last and first name, 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 Managed Care Report Companion Guide.

5.5 Continuity of Care Management Activities

For all cites in Section 5.5 through Section 5.5.1, please refer to the contract for all requirements.

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 until such time the Member can be served by a participating Physician, or can be transferred to a Health Plan that contracts with the Provider.

The universal Newborn Prior Authorization (PA) form has been developed for facilitating the PA process for services rendered in an office setting within sixty (60) Days following a Newborn's 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 through Section 5.5.2.1, please refer to the contract for all requirements.

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 Managed Care 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 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 Heath Records for the Member needing services not offered through the MCO's Core Benefit package.
B. All current Behavioral Health Records for the Member needing services 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 Benefit package.
D. Conclusions and a recommendation to the SCDHHS medical directors regarding the Medical Necessity of the care being requested 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.

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 Redetermination re-establishes Medicaid eligibility and 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 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.

6.0 Networks (Provider Network Requirements)

6.1 General Medicaid Managed Care Network Requirements

Section 6.1 through Section 6.1.8: 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 Members 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.

Section 6.1.9: MCOs are provided a daily Provider Junction Crosswalk file through their FTP site. MCOs should access this file to verify the Provider is a Qualified Medicaid Provider.

For all cites in Section 6.1.10 through Section 6.1.12, please refer to the contract for all requirements.

6.2 CONTRACTOR Provider Network

Sections 6.2 through Section 6.2.5.1: 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.

Providers of Medicaid services are organized into the following categories:

- Status One (1) = Required Provider; The MCO must have an executed contract with status one (1) Providers. Distance and drive time requirements for Providers with a status of one (1) are as follows:
  - Primary Care Physicians: For Providers acting in the capacity of a primary care Physician the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) PCP within thirty (30) miles and within forty-five (45) minutes or less driving time.
  - Required Specialists: For Providers acting as specialists the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) required specialist within fifty (50) miles and within seventy-five (75) minutes or less driving time.
  - 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.
- Status Two (2) = Required Provider; The MCO must have an executed contract

with status two (2) Providers. Distance and drive time requirements are not considered for network adequacy for Providers with a status of two (2).

- Status Three (3) = Attestation; MCOs will provide services through any means necessary. While MCOs may attest to status three (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 Four (4) = Additional Services provided for and reimbursed by the MCO that are not Core Benefit services. Such services must comply with the terms of the Policies and Procedures, and contract between SCDHHS and the MCOs. Before an MCO may offer these services, prior approval is required from the SCDHHS.

Network Adequacy Chart Service Groups Facility Providers							
Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Code	Taxonomy Description	Practice/Pricing Specialty	Medicaid Service Grouping	Contract Status 1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)
	00	21,22,23,28, 65, 66	314000000X	Skilled Nursing Facility		Nursing Home	2
	01	11,12,18,32,41, 81,82, 84,86	322D00000X	Residential Treatment Facility-Emotionally Disturbed Children		Psychiatric Residential Treatment Facility	2
			323P00000X	Psychiatric Residential Treatment Facility			
	01	11,12,18,32,41, 81,82, 84,86	261Q00000X	Clinic/Center		Inpatient Hospital	1
			273R00000X	General Acute Care Hospital-Psychiatric Unit			
			273Y00000X	General Acute Care Hospital-Rehabilitation Unit			
			281PC2000X	Chronic Disease Hospital-Children			
			282E00000X	Long Term Care Hospital			
			282N00000X	General Acute Care Hospital			
			282NC0060X	General Acute Care Hospital-Critical Access			
			282NC2000X	General Acute Care Hospital-Children			
			282NR1301X	General Acute Care Hospital-Rural			
			282NW0100X	General Acute Care Hospital-Women			
			283Q00000X	Psychiatric Hospital			
			283XC2000X	Rehabilitation Hospital-Children			
			284300000X	Specialized Hospital			
O	02	13,14,33,34,43,71, 72,73,74,75,76,77, 79,83,85,89	261Q00000X	Clinic/Center	80	Outpatient Hospital	1
			273R00000X	General Acute Care Hospital-Psychiatric Unit			
			273Y00000X	General Acute Care Hospital-Rehabilitation Unit			
			281PC2000X	Chronic Disease Hospital-Children			
			282E00000X	Long Term Care Hospital			
			282N00000X	General Acute Care Hospital			
			282NC0060X	General Acute Care Hospital-Critical Access			
			282NC2000X	General Acute Care Hospital-Children			
			282NR1301X	General Acute Care Hospital-Rural			
			282NW0100X	General Acute Care Hospital-Women			
			283Q00000X	Psychiatric Hospital			
			283XC2000X	Rehabilitation Hospital-Children			
			284300000X	Specialized Hospital			

Network Adequacy Chart Service Groups Ancillary and Professional							
Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status 1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)
B	19	103K00000X	Behavioral Analyst	BA	BA	Autism	2
B	19	106E00000X	Assistant Behavioral Analyst	BB	BB		
P	20	207RC0000X	Cardiovascular Disease	05	54	Cardiology	1
P	20	207RC0001X	Internal Medicine, Cardiac Electrophysiology	19	14, AC		
P	20	207RI0011X	Internal Medicine, Interventional Cardiology	19	14, AC		
F	10	261QM0850X	Adult Mental Health	28	28	Community Mental Health	2
F	10	261QM0855X	Adolescent and Children Mental Health	28	28		
F	10	261QM0801X	Mental Health Including Community Mental Health Center	28	28		
R	22	251K00000X	Agencies Public Health	51	51	DHEC	2
Y	76	332BP3500X	Paraenteral and Enteral Nutrition	N/A	59	Durable Medical Equipment	2
Y	76	332S00000X	Hearing Aid Equipment Supplier	N/A	59		
Y	76	332BX2000X	Supplier, Oxygen Equipment & Supplies	N/A	59		
Y	76	332B00000X	Supplier, DME & Medical Supplies	N/A	59		
P	20	207RG0100X	Gastroenterology	13	54	Gastroenterology	1
P	20	207RG0001X	Internal Medicine, Gastroenterology	19	54		
P	20	207RB0002X	Internal Medicine, Bariatric Medicine	19	14, AC		
P	20	208600000X	Surgeon	63	54	General Surgery	1
P	20	2086H0002X	Surgeon, Hospice and Palliative	63	54		
P	20	2086S0102X	Surgery Critical Care	63	54		
P	20	208600102X	Surgeon, Critical Care	63	54		
P	20	2086S0127X	Surgeon, Trauma Surgery	63	54		
P	20	207RH0003X	Hematology & Oncology	17, 30	54	Hematology and Oncology	1
P	20	207RH0000X	Internal Medicine, Hematology	19	14, AC		
P	20	207RX0202X	Internal Medicine, Medical Oncology	19	14, AC		
D	60	251E00000X	Home Health	N/A	00	Home Health	2
P	20	207RI0200X	Internal Medicine, Infectious Disease	19	14, AC	Infectious Disease	2
Y	80	291U00000X	Clinical Medical Laboratory	N/A	54	Laboratory/X-ray	2
Y	80	291900000X	Military Clinical Medical Laboratory	N/A	54		
Y	81	335V00000X	Portable X-Ray Supplier	N/A	54		
Y	81	293D00000X	Laboratory Physiological Laboratory	N/A	54		
Y	81	261QM1200X	Ambulatory Care Facility- Magnetic Resonance Imaging	N/A	54		
Y	81	261QR0206X	Ambulatory Health Care Facilities/Clinic-Center, Radiology, Mammography	N/A	54		
Y	81	261QR0208X	Radiology, Mamography	N/A	54		
Y	81	261QR0207X	Radiology, Mobile Mamography	N/A	54		
Y	81	261QR0200X	Imaging Facility	N/A	54		
Y	81	2471M1202X	Magnetic Resonance Imaging	N/A	54		
Y	81	261QS1200X	Sleep Disorder Diagnostic	N/A	54		
M	19	101Y00000X	Counselor Behavioral Health	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW	Licensed Mental Health Professionals	1
M	19	1041C0700X	Behavioral Health & Social Service Providers/Social Workers	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW		
M	19	106H00000X	Behavioral Health & Social Service Providers/Marriage and Family Therapy	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW		
M	19	101YP1600X	Counselor- Pastoral	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW		
M	19	101YS0200X	Counselor- School	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW		
M	19	101YM0800X	Behavioral Health & Social Service Providers/Mental Health	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW		
M	19	104100000X	Social Worker	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW		
M	19	101YP2500X	Professional Behavioral Health & Social Service Providers/Social Workers	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW		
P	20	207RN0300X	Internal Medicine, Nephrology	19	14, AC	Nephrology	1
P	20	2084P2900X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Neurodevelopmental	22	54	Neurology	1
P	20	2084A0401X	Psychiatry & Neurology, Addiction Medicine	48	54		
P	20	2084N0600X	Allopathic & Osteopathic Physicians/Neurophysiology	48	54		
P	20	2088F0040X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Vascular Neurology	22	54		

Network Adequacy Chart Service Groups Ancillary and Professional

Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status 1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)
N	19	225X00000X	Occupational Therapist	87	84	Occupational Therapy	1
N	19	225XR0403X	Occupational Therapist, Driving & Community Mobility	87	84		
N	19	225XE0001X	Occupational Therapist, Enviromental Modification	87	84		
N	19	225XE1200X	Occupational Therapist, Ergonomics	87	84		
N	19	225XF0002X	Occupational Therapist, Feeding, Eating, Swallowing	87	84		
N	19	225XG0600X	Occupational Therapist, Gerentology	87	84		
N	19	225XH1200X	Occupational Therapist, Hand	87	84		
N	19	225XH1300X	Occupational Therapist, Human Factors	87	84		
N	19	225XL0004X	Occupational Therapist, Low Vision	87	84		
N	19	225XM0800X	Occupational Therapist, Mental Health	87	84		
N	19	225XN1300X	Occupational Therapist, neurorehabilitation	87	84		
N	19	225XP0200X	Occupational Therapist, Pediatrics	87	84		
N	19	225XP0019X	Occupational Therapist, Physical Rehabilitation	87	84		
P	20	207VX0000X	Obstetrics and Gynecology, Obstetrics	26	14, AC	OB/GYN	1
P	20	207VE0102X	Obstetrics and Gynecology, Reproductive Endrocrinology	27	14, AC		
P	20	207V00000X	Obstetrics and Gynecology	27	14, AC		
P	20	207VB0002X	Obstetrics and Gynecology, Bariatric	27	14, AC		
P	20	207VC0200X	Obstetrics and Gynecology, Critical Care	27	14, AC		
P	20	207VX0201X	Obstetrics and Gynecology, Gynecologic Oncology	27	14, AC		
P	20	207VG0400X	Obstetrics and Gynecology, Gynecology	27	14, AC		
P	20	207VH0002X	Obstetrics and Gynecology, Hospice and Palliative Care	27	14, AC		
P	20	207VM0101X	Obstetrics and Gynecology, Maternal and Fetal Medicine	27	14, AC		
X	32	156FX1800X	Optician	33	33	Optometry	1
X	33	152W00000X	Optometrist	34	72		
X	33	152WC0802X	Optometrist, Corneal and Contact Management	34	72		
X	33	152WL0500X	Optometrist, Low Vision Rehabilitation	34	72		
X	33	152WX0102X	Optometrist, Occupational Vision	34	72		
X	33	152WP0200X	Optometrist, Pediatrics	34	72		
X	33	152WS0006X	Optometrist, Sports Vision	34	72		
X	33	152WV0400X	Optometrist, Vision Therapy	34	72		
P	20	207WX0200X	Allopathic & Osteopathic Physicians/Ophthalmic Plastic and Reconstructive Surgery	31	54		
P	20	207WX0009X	Allopathic & Osteopathic Physicians/Glaucoma Specialist	31	54		
P	20	207WX0107X	Allopathic & Osteopathic Physicians/Retina Specialist	31	54		
P	20	207W00000X	Opthamology	31	54		
Y	76	222Z00000X	Orthotist	N/A	59	Othotics/Prosthetics	2
Y	76	224P00000X	Prosthetist	N/A	59		
Y	76	332BC3200X	Supplier, Prosthetics & Orthotics	N/A	59		
Y	76	335E00000X	Supplier, Prosthetics & Orthotics	N/A	59		
P	20	207Y00000X	Otolaringology	36	54	Otolaringology/Otorihnolaringology	1
P	20	207YS0123X	Otolaringology, Facial Plastic Surgery	36, 69	54		
P	20	207YX0602X	Otolaringology, Otolaryngic Allergy	36	54		
P	20	207YX0905X	Otolaringology, Otolaryngology/Facial Plastic surgery	36, 69	54		
P	20	207YX0901X	Otolaringology, Otology & neurotology	36	54		
P	20	207YP0228X	Otolaringology, Pediatric	AA	AA		
P	20	207YX0007X	Otolaringology, Plastic Surgery Head & Neck	36, 69			
P	20	207YS0012X	Otolaringology, Sleep Medicine	36			

Network Adequacy Chart Service Groups Ancillary and Professional							
Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status 1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)
N/A	70	333600000X	Supplier, Pharmacy	N/A	N/A	Pharmaceutical Services	2
N/A	70	3336C0002X	Supplier, Pharmacy Clinic	N/A	N/A		
N/A	70	3336C0003X	Supplier, Retail Pharmacy	N/A	N/A		
N/A	70	3336C0004X	Supplier, Compounding Pharmacy	N/A	N/A		
N/A	70	3336H0001X	Supplier, Home Infusion Therapy Pharmacy	N/A	N/A		
N/A	70	3336I0012X	Supplier, Institutional Pharmacy	N/A	N/A		
N/A	70	3336L0003X	Supplier, Long Term Care Pharmacy	N/A	N/A		
N/A	70	3336M0002X	Supplier, Mail Order Pharmacy	N/A	N/A		
N/A	70	3336M0003X	Supplier, Managed Care Organization Pharmacy	N/A	N/A		
N/A	70	3336N0007X	Supplier, Nuclear Pharmacy	N/A	N/A		
N/A	70	3336S0011X	Supplier, Specialty Pharmacy	N/A	N/A		
P	20	2080A0000X	Pediatrics, Adolescent	40	14, AC	Pediatrics	1
P	20	208000000X	Pediatrics	40	14, AC		
	20	207RA0000X	Internal Medicine, Adolescent Medicine	19	14, AC		
N	19	225100000X	Physical Therapist	85	84	Physical Therapy	1
N	19	2251C2600X	Physical Therapist, Cardiopulmonary	85	84		
N	19	2251E1300X	Physical Therapist, Electrophysiology	85	84		
N	19	2251E1200X	Physical Therapist, Ergonomics	85	84		
N	19	2251G0304X	Physical Therapist, Geriatrics	85	84		
N	19	2251H1200X	Physical Therapist, Hand	85	84		
N	19	2251H1300X	Physical Therapist, Human Factors	85	84		
N	19	2251N0400X	Physical Therapist, Neurology	85	84		
N	19	2251X0800X	Physical Therapist, Orthopedic	85	84		
N	19	2251P0200X	Physical Therapist, Pediatrics	85	84		
N	19	2251S0007X	Physical Therapist, Sports	85	84		
N	19	261QP2000X	Physical Therapy	85	84		
P	20	207Q00000X	Family Medicine	12	14, AC	Primary Care	1
P	20	207QA0000X	Family Medicine, Addolescent	12	14, AC		
P	20	207QA0505X	Family Medicine, Adult	12	14, AC		
P	20	207QB0002X	Family Medicine, Bariatric	12	14, AC		
P	20	207QG0300X	Family Medicine, Geriartric	12	14, AC		
P	20	207QH0002X	Family Medicine, Hospice and Palliative Medicine	12	14, AC		
P	20	207QS0010X	Family Medicine, Sports Medicine	12	14, AC		
P	20	207QS1201X	Family Medicine, Sleep Medicine	12	14, AC		
P	20	2084P0005X	Allopathic & Osteopathic Physicians/Preventive Medicine, Public Health & General Preventive Medicine	14	14, AC		
P	20	208D00000X	General Practice	14	14, AC		
P	20	207RG0300X	Internal Medicine, Geriatric Medicine	19	14, AC		
P	20	207R00000X	Internal Medicine	19	14, AC		
P	20	207RS0012X	Internal Medicine, Sleep Medicine	19	14, AC		
P	20	207RS0010X	Internal Medicine, Sports Medicine	19	14, AC		
P	20	207RC0200X	Internal Medicine, Critical Care	19	14, AC		
Q	22	261QF0400X	Ambulatory Health Care Facilities/Clinic/Center FQHC	50	00		
Q	22	261QR1300X	Ambulatory Health Care Facilities/Clinic/Center RHC	97	00		

Network Adequacy Chart Service Groups Ancillary and Professional							
Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status 1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)
M	19	103G00000X	Clinical NeuroPsychologist	82	82	Psychologist	1
M	19	103GC0700X	Clinical Neuropsychologist	82	82		
M	19	103TC0700X	Behavioral Health & Social Service Providers/Psychologist, Clinical	82	82		
M	19	103T00000X	Behavioral Health & Social Service Providers/Psychologist	82	82		
M	19	103TA0700X	Behavioral Health & Social Service Providers/Psychologist, Adult Development & Aging	82	82		
M	19	103TC2200X	Behavioral Health & Social Service Providers/Psychologist, Clinical Child Adolescent	82	82		
M	19	103TB0200X	Behavioral Health & Social Service Providers/Psychologist, Cognitive & Behavioral	82	82		
M	19	103TC1900X	Behavioral Health & Social Service Providers/Psychologist, Counseling	82	82		
M	19	103TE1000X	Behavioral Health & Social Service Providers/Psychologist, Educational	82	82		
M	19	103TE1100X	Behavioral Health & Social Service Providers/Psychologist, Exercise and Sport	82	82		
M	19	103TF0000X	Behavioral Health & Social Service Providers/Psychologist, Family	82	82		
M	19	103TF0200X	Behavioral Health & Social Service Providers/Psychologist, Forensic	82	82		
M	19	103TP2701X	Behavioral Health & Social Service Providers/Psychologist, Group Psychotherapy	82	82		
M	19	103TH0004X	Behavioral Health & Social Service Providers/Psychologist, Health	82	82		
M	19	103TH0100X	Behavioral Health & Social Service Providers/Psychologist, Health Service	82	82		
M	19	103TM1700X	Behavioral Health & Social Service Providers/Psychologist, Men & Masculinity	82	82		
M	19	103TM1800X	Behavioral Health & Social Service Providers/Psychologist, Mental Retardation	82	82		
M	19	103TP0016X	Behavioral Health & Social Service Providers/Psychologist, Prescribing	82	82		
M	19	103TP0814X	Behavioral Health & Social Service Providers/Psychologist, Psychoanalysis	82	82		
M	19	103TP2700X	Behavioral Health & Social Service Providers/Psychologist, Psychotherapy	82	82		
M	19	103TR0400X	Behavioral Health & Social Service Providers/Psychologist, Rehabilitation	82	82		
M	19	103TS0200X	Behavioral Health & Social Service Providers/Psychologist, School	82	82		
M	19	103TW0100X	Behavioral Health & Social Service Providers/Psychologist, Women	82	82		
P	20	207RP1001X	Internal Medicine, Pulmonary Disease	19	14, AC	Pulmonary Medicine	1
E	10	251S00000X	Community Behavioral Health	20	20	Rehabilitative Behavioral Health	1
V	22	251300000X	Local Education Agency	95	95		
G	10	276400000X	Rehabilitation Substance Use Disorder	90	90	Substance Abuse Treatment	2
G	10	324500000X	Substance Abuse Disorder	90	90		
G	10	261QR0405X	Clinic/Center-Rehab Substance Abuse	90	90		
M	19	101YA0400X	Behavioral Health & Social Service Providers/Addiction	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW		
M	19	103TA0400X	Behavioral Health & Social Service Providers/Psychologist, Addiction	82	82		
L	20	207LA0401X	Anesthesiology, Addiction Medicine	03	03		
P	20	207QA0401X	Family Medicine, Addiction Medicine	12	14, AC		
P	20	2084P0802X	Addiction Psychiatry	48	54		
P	20	207RA0401X	Internal Medicine, Addiction Medicine	19	14, AC		
J	19	231H00000X	Speech, Language and Hearing/Audiologist	04	04	Speech and Audiology Therapy	1
J	19	237600000X	Audiologist- Hearing Aid Fitter	04	04		
J	19	231HA2400X	Speech, Language and Hearing/Audiologist, assistive Tech	04	04		
N	19	235Z00000X	Speech, Language and Hearing Service Providers	04, 84, 85,87	04, 84, 85,87		

Network Adequacy Chart Service Groups Ancillary and Professional

Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status 1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)
P	20	2084H0002X	Neuropsychiatry	48	54	Psychiatry	1
P	20	2084S0010X	Psychiatry & Neurology, Sports Medicine	48	54		
P	20	2084P0800X	Psychiatry	48	54		
P	20	2084B0002X	Psychiatry & Neurology, Bariatric Medicine	48	54		
P	20	2084P0804X	Psychiatry & Neurology, Child & Adolescent	49, AA	54, AA		
P	20	2084F0202X	Psychiatry & Neurology, Forensic Psychiatry	48	54		
P	20	2084P0805X	Psychiatry & Neurology, Geriatric Psychiatry	48	54		
P	20	2084P0015X	Psychiatry & Neurology, Psychosomatic Medicine	48	54		
P	20	2084S0012X	Psychiatry & Neurology, Sleep Medicine	48	54		
P	20	2085U0001X	Psychiatry & Neurology, Psychiatry	48	54		
P	20	2084N0400X	Psychiatry and Neurology, Neurology	22	54		
P	20	2084N0402X	Psychiatry and Neurology, Child Neurology	54, AA	54, AA		
P	20	207VF0040X	Urologist	N/A	N/A	Urology	1
P	20	208800000X	Urology	N/A	N/A		
N/A	21	261QP2300X	Primary Care	N/A	N/A	[redacted]	
N/A	21	261QM1300X	MultiSpecialty Group Practice	N/A	N/A		
N/A	21	193200000X	Group/Multi-Specialty	N/A	N/A		
N/A	21	193400000X	Group/Single-Specialty	N/A	N/A		
N/A	22	261QM1300X	MultiSpecialty Group Practice	N/A	N/A		
N/A	22	193200000X	Group/Multi-Specialty	N/A	N/A		
N/A	22	193400000X	Group/Single-Specialty	N/A	N/A		
N/A	34	261QM1300X	MultiSpecialty Group Practice	N/A	N/A		
N/A	34	193200000X	Group/Multi-Specialty	N/A	N/A		
N/A	34	193400000X	Group/Single-Specialty	N/A	N/A		
N/A	36	261QM1300X	MultiSpecialty Group Practice	N/A	N/A		
N/A	36	193200000X	Group/Multi-Specialty	N/A	N/A		
N/A	36	193400000X	Group/Single-Specialty	N/A	N/A		
N/A	38	261QM1300X	MultiSpecialty Group Practice	N/A	N/A		
N/A	38	193200000X	Group/Multi-Specialty	N/A	N/A		
N/A	38	193400000X	Group/Single-Specialty	N/A	N/A		
N/A	41	193200000X	Group/Multi-Specialty	N/A	N/A		
N/A	41	193400000X	Group/Single Specialty	N/A	N/A		
N/A	41	332H00000X	Group Eyewear Supplier	N/A	N/A		
T	22	261QM2500X	Ambulatory Health Care Facility, Medical Specialty	93	93	Ambulatory Centers	2
T	22	261Q00000X	Ambulatory Health Care Facility, Clinic	93	93		
T	22	261QM1300X	Ambulatory Health Care Facilities/Clinic/Center	93	93		
N/A	22	261QR0401X	Ambulatory Health Care Facility, Comprehensive Outpatient Rehabilitation Facility	N/A	N/A		
N/A	22	261QR0400X	Ambulatory Health Care Facility, Rehabilitation Facility	N/A	N/A		
N/A	22	261QF0050X	Ambulatory Health Care Facilities/Family Planning	N/A	N/A		
K	22	261QB0400X	Ambulatory Health Care Facilities/Clinic/Birthing Center	06	06		
V	22	261QD1600X	Ambulatory Care Facility-Developmental Disabilities	95	95		
V	22	261QG0250X	Ambulatory Care Facility- Genetics	95	95		
V	22	261QH0700X	Ambulatory Health Care Facility, Hearing and Speech	95	95		
V	22	261QS0132X	Ambulatory Health Care Facilities/Ophthalmologic Surgery	95	95		
V	22	261QI0500X	Ambulatory Health Care Facilities/Clinic/Center-Infusion Therapy	95	95		
T	22	261QA1903X	Ambulatory Surgical Center	93	93		
T	22	261QE0800X	Ambulatory Surgical Center	93	93		
L	20	207L00000X	Anesthesiology	03	03	Anesthesiology	3
L	20	207LC0200X	Anesthesiology, Critical Care Medicine	03	03		
L	20	207LP3000X	Anesthesiology, Pediatric	03, AA	03, AA		
L	19	367500000X	Advanced Practice Nursing Provider/Nurse Anesthetist	25	25		
P	20	207K00000X	Allergy and Immunology	02	54	Allergy and Immunology	2
P	20	207KA0200X	Allergy and Immunology, Allergy	02	54		
P	20	207KI0005X	Allergy and Immunology, Clinical and Laboratory Immunology	02	54		
P	20	207RA0201X	Internal Medicine, Allergy and Immunology	19	14, AC		
P	20	207RI0001X	Internal Medicine, Clinical & laboratory Immunology	19	14, AC		
E	10	251B00000X	Case Management	20	20	Case Management	4
E	10	171M00000X	Case Management	20	20		

Network Adequacy Chart Service Groups Ancillary and Professional							
Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status 1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)
Y	37	111N00000X	Chiropractor	07	54	Chiropractor	2
Y	37	111NI0013X	Chiropractor, Independent Medical Examiner	07	54		
Y	37	111NI0900X	Chiropractor, Internest	07	54		
Y	37	111NN0400X	Chiropractor, Neurology	07	54		
Y	37	111NN1001X	Chiropractor, Nutrition	07	54		
Y	37	111NX0100X	Chiropractor, Occupational Medicine	07	54		
Y	37	111NX0800X	Chiropractor, Orthopedic	07	54		
Y	37	111NP0017X	Chiropractor, Pediatric Chiropractor	07	54		
Y	37	111NR0200X	Chiropractor, Radiology	07	54		
Y	37	111NR0400X	Chiropractor, Rehabilitation	07	54		
Y	37	111NS0005X	Chiropractor, Sport Physician	07	54		
Y	37	111NT0100X	Chiropractor, Thermography	07	54		
P	20	208C00000X	Surgeon, Colon & Rectal	62	54	Colon and Rectal Surgery	2
A	30	1223S0112X	Oral and Maxillofacial Surgery (Dentist)	08, 35, 43	72	Dental	4
A	30	12230000X	Dentist	08, 35, 43	72		
A	30	1223D0001X	Dental Public Health	08, 35, 43	72		
A	30	1223D0004X	Dental Anesthesiologist	08, 35, 43	72		
A	30	1223E0200X	Endodontics	08, 35, 43	72		
A	30	1223G0000X	General Practice	08, 35, 43	72		
A	30	1223P0106X	Oral and Maxillofacial Pathology	08, 35, 43	72		
A	30	1223X0008X	Oral and Maxillofacial Radiology	08, 35, 43	72		
A	30	1223X0400X	Orthodontics and Dentofacial Orthopedics	08, 35, 43	72		
A	30	1223P0221X	Pediatric Dentistry	08, 35, 43	72		
A	30	1223P0300X	Periodontics	08, 35, 43	72		
A	30	1223P0700X	Prosthodontics	08, 35, 43	72		
A	30	204E00000X	Surgeon, Oral & Maxillofacial	63	54		
P	20	207N00000X	Dermatology	09	54	Dermatology	2
P	20	207N10002X	Dermatology, Clinical and Lab Dermatological Immunology	09	54		
P	20	207ND0101X	Dermatology, MOHS-Micrographic Surgery	09	54		
P	20	207ND0900X	Dermatology, Dermapathology	09	54		
P	20	2081P0010X	Allopathic & Osteopathic Physicians/Dermatology, Clinical & Laboratory Dermatological Immunology	09	54		
P	20	207NS0135X	Dermatology, Procedural	09	54		
Q	22	261QE0700X	End Stage Renal Disease	21	54	ESRD Clinic	3
P	20	207SC0300X	Allopathic & Osteopathic Physicians/Clinical Cytogenetic	19	14	Genetics	3
P	20	207SG0201X	Clincal Genetics	19	14		
K	19	133V00000X	Registered Dietician	DT	DT	Dietician/Nutrition	2
K	19	133VN1006X	Registered Dietician, Nutrition, Metabolic	DT	DT		
K	19	133VN1004X	Dietician, Pediatric	DT	DT		
K	19	133VN1005X	Dietician, Renal	DT	DT		
U	22	163WD0400X	Diabetes Educator	94	94		
U	22	133NN1002X	Nutrition, Education	94	94		
P	20	207RE0101X	Internal Medicine, Endocrinology Diabetes & Metabolism	19	14, AC	Endocrinology	2
P	20	207P00000X	Emergency Medicine	10	54	Emergency Medicine	3
P	20	207PE0004X	Emergency Medicine, Emergency Medical Services	10	54		
P	20	207PH0002X	Emergency Medicine, Hospice and Palliative Medicine	10	54		
P	20	207PT0002X	Emergency Medicine, Medical Toxicology	10	54		
P	20	207PS0010X	Emergency Medicine, Sports Medicine	10	54		
P	20	207PE0005X	Emergency Medicine, Under sea & Hyperbaric	10	54		
1-9, $	61	Currently Atypical		N/A	77	Home and Community Based Services	4
D	60	251G00000X	Hospice Care, Community Based	N/A	00	Hospice	4
P	20	208M00000X	Hospitalist	19	14	Hospitalist	3
K	19	175M00000X	Lay Midwife	06	06	Midwife	3
K	19	176B00000X	Nurse Midwife	06	06		
K	19	367A00000X	Advanced Practice Nursing Provider/Certified Nurse Midwife	06	06		

Network Adequacy Chart Service Groups Ancillary and Professional							
Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status 1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)
Y	82	341600000X	Ambulance	N/A	00	Medical Transportation	3
Y	82	3416A0800X	Ambulance, Air Transport	N/A	00		
Y	82	3416L0300X	Ambulance, Land Transport	N/A	00		
Y	82	3416S0300X	Ambulance, Water Transport	N/A	00		
D	84	341600000X	Ambulance	N/A	00		
D	84	3416A0800X	Ambulance, Air Transport	N/A	00		
D	84	3416L0300X	Ambulance, Land Transport	N/A	00		
D	84	3416S0300X	Ambulance, Water Transport	N/A	00		
K	19	363L00000X	Nurse Practitioner	86	86	Nurse Practitioner	2
K	19	363LA2100X	Nurse Practitioner, Acute Care	86	86		
K	19	363LA2200X	Nurse Practitioner, Adult Health	86	86		
K	19	363LC1500X	Nurse Practitioner, Community Health	86	86		
K	19	363LC0200X	Nurse Practitioner, Critical Care Medicine	86	86		
K	19	363LF0000X	Nurse Practitioner, Family	86	86		
K	19	363LG0000X	Nurse Practitioner, Gerontology	86	86		
K	19	363LN0000X	Nurse Practitioner, Neonatal	86	86		
K	19	363LN0005X	Nurse Practitioner, Neonatal Critical Care	86	86		
K	19	363LX0001X	Nurse Practitioner, Obstetrics & Gerontology	86	86		
K	19	363LX0106X	Nurse Practitioner, Occupational Health	86	86		
K	19	363LP0200X	Nurse Practitioner, Pediatrics	86	86		
K	19	363LP0222X	Nurse Practitioner, Pediatrics Critical Care	86	86		
K	19	363LP1700X	Nurse Practitioner, Perinatal	86	86		
K	19	363LP2300X	Nurse Practitioner, Primary Care	86	86		
K	19	363LP0808X	Nurse Practitioner, Psychiatric	86	86		
K	19	363LS0200X	Nurse Practitioner, School	86	86		
K	19	363LW0102X	Nurse Practitioner, Women's Health	86	86		
P	20	208600105X	Surgeon, Hand Surgery	63	54	Orthopedic Surgery	2
P	20	207XX0801X	Surgeon, Orthopaedic Trauma	67	54		
P	20	207X00000X	Surgeon, Orthopaedic Surgery	67	54		
P	20	207XS0117X	Surgeon, Orthopaedic Surgery of Spine	67	54		
P	20	207XS0114X	Surgeon, Adult Reconstructive Orthopaedic Surgery	67	54		
P	20	207XX0004X	Surgeon, Foot and Ankle	67	54		
P	20	207XS0106X	Surgeon, Hand	63	54		
P	20	2086S0105X	Surgery, Surgery of the hand	69	54		
P	20	207XX0005X	Surgeon, Sports Medicine	63	54		
P	20	207RH0002X	Internal Medicine, Hospice & palliative care	19	14, AC	Pain Medicine	2
P	20	208VP0014X	Pain Medicine, Interventional Pain Medicine	03, 14, 54	03, 14, 54		
P	20	2084V0102X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Pain Medicine	22, 48	54		
P	20	2081P2900X	Pain Medicine, Interventional Pain Medicine	03, 14, 54	03, 14, 54		
P	20	208VP0000X	Physicians, Pain Management	03, 14, 54	03, 14, 54		
P	20	207LH0002X	Anesthesiology, Hospice and Palliative Care	03, 14, 54	03, 14, 54		
P	20	207LP2900X	Anesthesiology, Pain Medicine	03, 14, 54	03, 14, 54		
P	20	207ZB0001X	Pathology, Blood Banking & Transfusion Medicine	38	54	Pathology	3
P	20	207ZP0104X	Pathology, Chemical Pathology	38	54		
P	20	207ZC0006X	Pathology, Clinical Pathology	39	54		
P	20	207ZP0105X	Pathology, Clinical Pathology/Laboratory	39	54		
P	20	207ZC0500X	Pathology, Cytopathology	38	54		
P	20	207ZD0900X	Pathology, Dermapathology	38	54		
P	20	207ZF0201X	Pathology, Forensic Pathology	38	54		
P	20	207ZH0000X	Pathology, Hematology	38	54		
P	20	207ZP0101X	Anatomic Pathology	38	54		
P	20	207ZI0100X	Pathology, Immunopathology	38	54		
P	20	207ZM0300X	Pathology, Medical Microbiology	38	54		
P	20	207ZP0007X	Pathology, Molecular Genetic Pathology	38	54		
P	20	207ZN0500X	Pathology, Neuropathology	38	54		
P	20	207ZP0213X	Pathology, Pediatric Pathology	AA	AA		
P	20	207ZP0102X	Anatomic Pathology & Clinical Pathology	38	54		

22

Network Adequacy Chart Service Groups Ancillary and Professional							
Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status 1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)
P	20	2080I0007X	Pediatrics, Clinical & Laboratory Immunology	AA	AA	Pediatric Subspecialists	2
P	20	2080P0006X	Pediatrics, Developmental Behavioral	AA	AA		
P	20	2080C0008X	Allopathic & Osteopathic Physicians/Pediatrics, Child Abuse Pediatrics	AA	AA		
P	20	2080H0002X	Pediatrics, Hospice and Palliative	AA	AA		
P	20	2080T0002X	Pediatrics, Medical Toxicology	AA	AA		
P	20	2080N0001X	Pediatrics, Neonatal-Perinatal	AA	AA		
P	20	2080P0008X	Pediatrics, Neurodevelopmental Disabilities	AA	AA		
P	20	2080P0201X	Pediatrics, Allergy and Immunology	AA	AA		
	20	207NP0225X	Dermatology, Pediatric	AA	AA		
P	20	2080P0202X	Pediatrics, Cardiology	AA	AA		
P	20	2080P0203X	Pediatrics, Critical Care	AA	AA		
P	20	2080P0204X	Pediatrics, Emergency Medicine	AA	AA		
P	20	2080P0205X	Pediatrics, Endocrinology	AA	AA		
P	20	2080P0206X	Pediatrics, Gastroenterology	AA	AA		
P	20	207PP0204X	Emergency Medicine, Pediatric	AA	AA		
P	20	2080P0208X	Pediatrics, Infectious Disease	AA	AA		
P	20	2080P0207X	Pediatrics, Hematology Oncology	AA	AA		
P	20	2080P0210X	Pediatrics, Nephrology	AA	AA		
P	20	2080P0214X	Pediatrics, Pulmonology	AA	AA		
P	20	2080P0216X	Pediatrics, Rheumatology	AA	AA		
P	20	2080T0004X	Pediatrics, Transplant Heapatology	AA	AA		
P	20	2080S0012X	Pediatrics, Sleep Medicine	AA	AA		
P	20	2080S0010X	Pediatrics, Sports Medicine	AA	AA		
P	20	2083P0901X	Allopathic & Osteopathic Physicians/Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine	AA	AA		
P	20	2088P0231X	Allopathic & Osteopathic Physicians/Urology, Pediatric Urology	AA	AA		
P	20	207XP3100X	Surgeon, Pediatric Orthopaedic Surgery	AA	54		
P	20	2085R0204X	Pediatric Radiology	AA	AA		
P	20	2086S0120X	Surgeon, Pediatric	AA	AA		
P	20	2086S0122X	Surgeon, Plastic and Reconstructive	69	54	Plastic Surgery	3
P	20	208200000X	Surgeon, Plastic Surgery	69	54		
P	20	2081P0004X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology, Female Pelvic Medicine and Reconstructive Surgery	63	54		
P	20	261QU0200X	Female Pelvic Medicine & Reconstructive Surgery	63	54		
P	20	2082S0099X	Surgeon, Plastic Surgery Head & Neck	69	54		
P	20	2082S0105X	Surgeon, Plastic Surgery of Hand	69	54		
P	20	207NI0002X	Allopathic & Osteopathic Physicians/Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine	29, 19	14, 54	Physical Medicine/Rehabilitation	2
P	20	208100000X	Physician, Physical Medicine & Rehabilitation	19, 29	14, 54, AC		
P	20	204C00000X	Physician, Neuromusculoskeletal Medicine, Sports Medicine	19, 29	14, 54, AC		
P	20	2081S0010X	Physician, Physical Medicine & Rehab, Sports Medicine	19, 29	14, 54, AC		
P	20	204D00000X	Physician, Neuromusculoskeletal Medicine & OMM	19, 29	14, 54, AC		
P	20	2083X0100X	Physician, Occupational Medicine	29	54		

Network Adequacy Chart Service Groups Ancillary and Professional

Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status 1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply, distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)
K	19	363A00000X	Physician Assistant	PA	86	Physician Assistant	2
K	19	363AM0700X	Physician Assistant	PA	86		
K	19	363AS0400X	Physician Assistants & Advanced Practice Nursing Providers/Physician Assistant, Surgical	PA	86		
K	19	364SA2200X	Physician Assistants & Advanced Practice Nursing Providers/ Nurse Practitioner, Adult Health	PA	86		
K	19	364SP0808X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health	PA, 86	86		
K	19	364S00000X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist	PA, 86	86		
K	19	364SE0003X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Emergency	PA, 86	86		
K	19	364SC0200X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Critical Care Medicine	PA, 86	86		
K	19	364SM0705X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Medical-Surgical	PA, 86	86		
K	19	364SP0810X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family	PA, 86	86		
K	19	363LG0600X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Gerontology	PA, 86	86		
K	19	364SA2100X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Acute Care	PA, 86	86		
K	19	364SC1501X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Community Health/Public Health	PA, 86	86		
K	19	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Family Health	PA, 86	86		
K	19	364SP0200X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Pediatrics	PA, 86	86		
K	19	364SP0809X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health, Adult	PA, 86	86		
K	19	364SX0200X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Oncology	PA, 86	86		
Y	35	213E00000X	Podiatrist	47	54	Podiatry	3
Y	35	213ES0103X	Podiatrist, Foot and Ankle Surgery	47	54		
Y	35	213ES0131X	Podiatrist, Foot Surgery	47	54		
Y	35	213EG0000X	Podiatrist, General Practice	47	54		
Y	35	213EP1101X	Podiatrist, Primary Podiatric Medicine	47	54		
Y	35	213EP0504X	Podiatrist, Public Medicine	47	54		
Y	35	213ER0200X	Podiatrist, Radiology	47	54		
Y	35	213ES0000X	Podiatrist, Sports Medicine	47	54		
P	20	2085R0202X	Radiology, Diagnostic	55	54	Radiology, Diagnostic	3
P	20	2085N0700X	NeuroRadiology	55	54		
P	20	2085D0003X	Allopathic & Osteopathic Physicians/Diagnostic Neuroimaging	55	54		
P	20	2085N0904X	Allopathic & Osteopathic Physicians/Nuclear Radiology	55	54		
P	20	2085R0203X	Allopathic & Osteopathic Physicians/Therapeutic Radiology	55	54		
P	20	207U00000X	Nuclear Medicine	24	54		
P	20	207UN0903X	Nuclear Medicine, In vivo, In vitro	24	54		
P	20	207UN0901X	Nuclear Medicine, Nuclear Cardiology	24	54		
P	20	207UN0902X	Nuclear Medicine, Imaging and Therapy	24	54		
P	20	207RM1200X	Internal Medicine, Magnetic Resonance Imaging	19	14, AC		
P	20	2085P0229X	Diagnostic Ultrasound Radiology	55	54		
P	20	2085B100X	Body Imaging	55	54		
P	20	207RR0500X	Internal Medicine, Rheumatology	19	14, AC	Rheumatology	2
P	20	207T00000X	Surgeon, Neurological	65	54	Surgery Neurological	2
P	20	2083P0500X	Physician, Environmental Medicine		54	Environmental Medicine	3
P	20	202K00000X	Allopathic & Osteopathic Physicians/Phlebology		54	Phlebology	3
P	20	202C00000X	Allopathic & Osteopathic Physicians/Independent Medical Examiner		54	Medical Examiner	3
P	20	2086S0129X	Surgeon, Vascular	61, 63	54	Vascular Surgery	2
P	20	2086X0206X	Surgeon, Oncology	63	54	Surgery Oncology	2
P	20	204F00000X	Surgeon, Transplant	63	54	Surgery	2
P	20	2085B0100X	Radiology, Vascular and Interventional	56	54	Theapeutic Radiology	3
P	20	2085R0001X	Radiation Oncology	56	54		
P	20	208G00000X	Surgeon, Thoracic	61, 63	54	Thoracic Surgery	2
	19	367H00000X	Anesthesiology Assistant	not currently enrolled by Medicaid	not currently enrolled by Medicaid	Not Categorized due to service category not specific enough to categorize or outside of managed care service array	N/A
	20	174400000X	Other Service Providers	N/A	N/A		
	22	251V00000X	Voluntary or Charitable Organization	N/A	N/A		
	22	171W00000X	Contractor Other Service Provider	N/A	N/A		
	20	207RT0003X	Internal Medicine, Transplant Hepatology	19	14, AC		
	20	207RI0008X	Internal Medicine, Hepatology	19	14, AC		

Network adequacy is determined by SCDHHS. Network adequacy is based on factors outlined in the Contract. If the submitted Provider network is determined to be inadequate by SCDHHS, the submitted Provider network, documentation and specific discrepancies by county is shared with MCO management. SCDHHS will take appropriate action as a result of discrepancies discovered during the network analysis which may include the following:

1. Instituting a Corrective Action Plan with the MCO.
2. Assessing liquidated damages for network adequacy discrepancies found in the network assessment.
3. Removing any county or affected counties not meeting minimum network adequacy requirements from the MCO's Service Area. Please see the network termination/transition process described below for additional information.

SCDHHS will notify the MCO of their network adequacy through the network adequacy analysis report. SCDHHS will notify the appropriate entities of any changes to an MCOs network Service Area.

SCDHHS may modify the auto assignment, or Member choice processes, at its discretion due to inadequate networks. Any modification will be communicated directly to the MCO along with a reason and implementation date of the change.

For all cites in Section 6.3 through Section 6.3.2.1, please refer to the contract for all requirements.

6.3 Provider Network Submission

Section 6.3.2.2: The MCO submits its entire Provider network to the SCDHHS as outlined in the contract. The format and template of the required submission may be found in the Managed Care Report Companion Guide. The entire Provider network must be submitted to the MCO's Required Submissions SharePoint site.

For all cites in Section 6.3.2.3 through Section 6.3.2.3.2, please refer to the contract for all requirements.

Section 6.3.2.4: The Network termination/transition process shall be initiated as a result of an inadequate network adequacy determined by:

1. During the bi-annual review of the Provider network listing spreadsheet, or during a review conducted at the discretion of SCDHHS.

   or

2. The loss of a required network Provider.

   or

3. Through a withdrawal of an MCO from a county or counties.

Should any of the above reasons for network termination/transition occur SCDHHS and the MCO will analyze the effect of the change on the MCO network. If the analysis indicates an inadequate network the following termination/transition process will be initiated.

1. **Notification:** Within (10) ten Business Days following the analysis, SCDHHS shall inform the MCO in writing of the county or counties that do not meet network adequacy.

2. **Suspension of Member Assignment and Choice:** SCDHHS will inform the Enrollment broker at the same time as the written notification to the MCO to suspend assignment and choice for the county or counties that do not meet network adequacy. The suspension shall be effective beginning with the first Day of the next available Enrollment period.

3. **Project Plan:** The MCO shall submit a termination/transition project plan to SCDHHS using an approved format that addresses Member and Provider notification and the timing of all termination/transition activities.

4. **Member Transfer:** All Members in the affected county or counties shall be transferred by the Enrollment broker to other MCOs using the auto-assignment process. This Member transfer will occur at the earliest possible date determined by the Enrollment broker.

5. **Termination/Transition Costs:** All Enrollment broker costs associated with the Member transfer process shall be the responsibility of the MCO. Payment of such costs shall be made to SCDHHS by check within thirty (30) Days of receipt of the termination/transition invoice.

A request by the MCO to reinstate Member assignment in a terminated county may only occur during the biannual submission of the network adequacy report. The MCO understands and acknowledges it will be excluded from submitting all of the necessary information for county reinstatement until the subsequent biannual network submission.

For all cites in Section 6.4 through Section 6.4.2.4, please refer to the contract for all requirements.

7.0 PAYMENTS

7.1 Financial Management

For all cites in Section 7.1 through Section 7.1.2, please refer to the contract for all requirements.

7.2 Medical Loss Ratio (MLR)

For all cites in Section 7.2.1 through Section 7.2.1.1, please refer to the contract for all requirements.

Section 7.2.1.2: Please see the Managed Care Report Companion Guide for instructions in completing the annual Medical Loss Ratio.

For all cites in Section 7.2.1.3 through Section 7.2.4.2, please refer to the contract for all requirements.

7.3 Capitation Payments from the Department to CONTRACTOR

Section 7.3.1.1 through Section 7.3.2.2: SCDHHS uses an actuarially sound methodology to develop its Capitation Payments. These methodologies can be found in the Managed Care Rate Book on the SCDHHS website, https://msp.scdhhs.gov/.

While the majority of Capitation Payments made to MCOs are automated some may be paid to the MCO through an adjustment process. If the adjustment processed by the SCDHHS Division of Managed Care 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 SCDHHS 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 Payment.

Capitation / Premium Payment Adjustment:

When it is determined by SCDHHS a Capitated 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 liaison to report any possible discrepancies.

Retrospective Review and Recoupment

Dual Eligible:

Beneficiaries who are Dual Eligibles (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. Capitation 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 Capitation Payment rate.

> 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.

Capitation Payments made for Deceased Membership:

There are instances where Capitation Payments might be made by the Department in error for Beneficiaries that have passed away. In all of these instances, the Department will seek to recoup the Capitation Payment that was made. Each month the MCO will receive a report from SCDHHS indicating those Members that have passed away where the agency made a Capitation Payment for the deceasedMember. 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. Capitation Payments for Members reflected on this report will be adjusted for the months the Member was deceased and a Capitation Payment was made by the Department. 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's end.

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 (levels refer to the levels NCQA had in effect for practices recognized under PCMH recognition standards prior to 2017):
    - 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
- Beginning with the 2017 NCQA standards for PCMH recognition, NCQA is no longer awarding recognition at varying levels (I, II, or III) as in the past; therefore, practices who become recognized under 2017 NCQA standards will be incentivized at the same level as those practices who were Level III under previous versions of NCQA's PCMH Recognition.
- 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 Managed Care Report 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 Managed Care Report Companion Guide.
  - 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 within 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 (including information regarding, Level I, Level II, and Level III, as applicable to those practices still recognized under a set of NCQA PCMH Recognition standards prior to 2017) 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 Managed Care Report 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 Managed Care 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 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 3 and the Managed Care 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 Capitation 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 the 1.5% withhold 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.

7.4 Payments from CONTRACTOR to Subcontractors

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

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 Medicaid 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 Medicaid 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 Rural Health Clinics on a quarterly basis. The table below reflect current wrap around methodology for Rural Health Clinics.

RHC WRAP PAYMENT METHODOLOGY

EFFECTIVE JANUARY 1, 2018

RHC	
Allowed CPT Codes (1)	**Exclusions from RHC Encounter Rate (3)**
Billable as a Medical Encounter:	11976,11981
T1015	58300,58301
99201-99205	59025 (TC Modifier)
99212-99215	70000 - 79999 (TC Modifier)
99241-99245	70000 Series - 70% removed for Tech component **(4)**
99381-99385	80000-89999
99391-99395	90378
Add. Codes for Bi-Annual Exams (Adults):	90630
99386	90656
99387	90657
99396	90658
99397	90670
Podiatry:	90620, 90621
Standard E&M codes - see above	90662
Ophthalmalogy:	90672
92002	90673
92004	90685-90688
92012	90707, 90710, 90715, 90716
92014	90732
Chiropractic:	93005
98940-98942	93017
In-Home Services	93041
99341-99345	93225
99347-99350	93325
Domiciliary or Rest Home Services:	93880
99324-99328	93970
99334-99337	97802, 97803
Skilled Nursing Facility Services:	99050
99304-99310	99051
99315-99316	99188
99318	99217 - 99999 *
Family Planning Service (separate visit):	A4264
99401-99402	G0447
Postpartum Care:	H0002
59430	H0004
Health Risk Assessment (Foster Care):	J1050
96160, 96161	J1950
Billable as a Behavioral Health Encounter: (2)	J7296
90791, 90792	J7297
90832-90834, 90836-90838	J7298
90839	J7300
90847, 96101	J7301
T1015/HE	J7307
	Q2035 - Q2039
	Q3014
	S4989
	S9452
	S9470
	*** - 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 RHC encounter service. They are includable in the WRAP "count".

(2) Behavioral Health Services codes that are considered as an eligible RHC 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 RHC 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 RHC encounter service rate and thus should not be separately reimbursed.

(4) The professional component of the 70000 series procedure codes are included in the RHC encounter service rate and thus should not be separately reimbursed.

(5) 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. Note: RHCs are allowed to separately bill obesity services, some of which are group. The group rates are the same as individual rates.

(6) Procedure codes will be reviewed annually to determine if updates are required in either billable encounter codes or excludable services.

The Medicaid MCO shall submit a report, quarterly, to its SharePoint quarterly library, of all paid Encounter/Claim data, by date of service, for all services rendered by RHCs for supplemental payment determination (wrap-around methodology). Services eligible for wrap-around methodology must meet Medicaid Fee-for-Service coverage requirements. The CONTRACTOR shall submit the data for each RHC in the format outlined in the Managed Care Report Companion Guide. This information shall be submitted in the required format no later than sixty (60) Days from 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.

The Department will complete an annual wrap-around reconciliation based on the RHC's fiscal year end. To complete this process, the following will be required:

1. Within one (1) year and sixty (60) Days of the MCO's quarterly RHC wrap-around report, all quarterly wrap-around files for the applicable quarter must be re-run (i.e. updated) in order to capture additional Encounter and payment data not available or processed when the initial quarterly RHC wrap-around report was originally submitted by the MCO.

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

The CONTRACTOR 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 SCDHHS required format found in the Managed Care Report Companion Guide. For your convenience an excel report template is available at https://msp.scdhhs.gov/managed_care/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.

Section 7.4.3.2 through Section 7.4.3.3: 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.

The Department has elected to utilize a Prospective Payment System (PPS) methodology for FQHC Provider reimbursements. Individual PPS rates will be shared with each MCO prior to the start of a new fiscal year. This document will indicate all current encounter reimbursement rates that must be paid for the new fiscal year and the eligible Providers. MCOs and FQHCs through their contractual relationship determine when full payment is made for services rendered by the FQHC. MCOs should only pay for codes that are reflected in the reimbursement methodology chart reflected in the table below.

WRAP PAYMENT METHODOLOGY

EFFECTIVE JULY 1, 2018

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
Ophthalmalogy:	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	J7296
Family Planning Service (separate visit):	J7297
99401-99402	J7298
Postpartum Care:	J7300
59430	J7301
Health Risk Assessment (Foster Care):	J7307
96160, 96161	80305
MNT/Nutritional Counseling/Obesity Initiative:	80307
97802-97803	G0480
	Q2035 - Q2039
Billable as a Behavioral Health Encounter: (2)	Q3014
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.

MCO Encounter Submission of FQHC Data:

SCDHHS will 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, of all paid Encounter/Claim data, by date of service, for all services rendered by FQHCs. The agency will use this data to review and audit prospective payments to confirm the entire encounter rate was paid to all participating FQHCs. The CONTRACTOR shall submit the data for each FQHC in the format outlined in the Managed Care Report Companion Guide. This information shall be submitted in the required format 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.

The Department will complete an annual review based on the FQHC's fiscal year end. To complete this process, the following will be required:

1. Within one (1) year and sixty (60) Days of the FQHC's quarterly report, all quarterly files for the applicable quarter must be re-run (i.e. updated) in order to capture additional Encounter and Claims data not available when the initial quarterly FQHC report was originally submitted by the MCO.

2. Transmission requirements remain the same as the quarterly submissions. That is, the updated files must 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 review 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 SCDHHS required format found in the Managed Care Report Companion Guide. For your convenience an excel report template is available at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates.

Initial Quarterly FQHC/RHC Report Schedule (Completed in Current Year)		
Service Dates of Quarterly Report	**Through Paid Date**	**Report Due Date**
January 1 – March 31	Claims Paid through May	May 31
April 1 – June 30	Claims Paid through August	August 31

Initial Quarterly FQHC/RHC Report Schedule (Completed in Current Year)		
SERVICE DATES OF QUARTERLY REPORT	**THROUGH PAID DATE**	**REPORT DUE DATE**
July 1 – September 30	Claims Paid through November	November 30
October 1 – December 31	Claims Paid through February	February 28
Final Annual Quarter Repeat FQHC/RHC Report (Completed a Year after Initial Report was Submitted to SCDHHS)		
SERVICE DATES OF FINAL QUARTERLY REPORT	**THROUGH PAID DATE**	**REPORT DUE DATE**
January 1 – March 31 (Previous Year)	Claims Paid through May	May 31 (365 days from original submission)
April 1 – June 30	Claims Paid through August	August 31 (365 days from original submission)
July 1 – September 30	Claims Paid through November	November 30 (365 days from original submission)
October 1 – December 31	Claims Paid through February	February 28 (365 days from original submission)

For all cites in Section 7.4.3.4, please refer to the contract for all requirements.

7.5 Copayments

Section 7.5: 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-ID)
- Members of a federally recognized Indian tribe are exempt from most Copayments. 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 through Section 7.6.2, please refer to the contract for all requirements.

7.7 Payment Standards

For all cites in Section 7.7 through Section 7.7.5.4, please refer to the contract for all requirements.

7.8 Prohibited Payments

For all cites in Section 7.8 through Section 7.8.7, please refer to the contract for all requirements.

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 of each year and follow SCDOI regulation 69-70, the Annual Audited Financial Reporting Regulation. The MCO must submit the annual financial report to its Annual Library on SharePoint in July of each year.

Section 7.9.2: For all cites in Section 7.9.2, please refer to the contract for all requirements.

7.10 Return of Funds

For all cites in Section 7.10 through Section 7.10.4, please refer to the contract for all requirements.

7.11 Medicaid Provider Tax Returns

For all cites in Section 7.11 through Section 7.11.4, please refer to the contract for all requirements.

8.0 Utilization Management

8.1 General Requirements

For all cites in Section 8.1, please refer to the contract for all requirements.

8.2 CONTRACTOR Utilization Management (UM) Program Requirements

For all cites in Section 8.2 through Section 8.2.2.3, please refer to the contract for all requirements.

8.3 CONTRACTOR Utilization Management (UM) Program Reporting Requirements

For all cites in Section 8.3 through Section 8.3.2, please refer to the contract for all requirements.

8.4 Practice Guidelines

For all cites in Section 8.4 through Section 8.4.5, please refer to the contract for all requirements.

8.5 Service Authorization

For all cites in Section 8.5 through Section 8.5.2.8, please refer to the contract for all requirements.

8.6 Timeframe of Service Authorization Decisions

For all cites in Section 8.6 through Section 8.6.2.5, please refer to the contract for all requirements.

8.7 Exceptions to Service Authorization Requirements

For all cites in Section 8.7 through Section 8.7.3.1, please refer to the contract for all requirements.

8.8 Emergency Service Utilization

For all cites in Section 8.8 through Section 8.8.3, please refer to the contract for all requirements.

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

For all cites in Section 8.9 through Section 8.9.5, please refer to the contract for all requirements.

9.0 Grievance and Appeals Procedures and Provider Disputes

Section 9.0: 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 of the Policy.

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.

Section 9.1.2: 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 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 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 the Grievance log and the Appeal log shall be uploaded to the MCO's SharePoint Quarterly Library.

For all cites in Section 9.1.3.1.2, please refer to the contract for all requirements.

For all cites in Section 9.1.4 through Section 9.1.6.1.5.3, please refer to the contract for all requirements.

Section 9.1.6.2.1: 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 9.1.6.2.2 through Section 9.1.6.3.1, please refer to the contract for all requirements.

Section 9.1.6.3.1.1 through Section 9.1.6.3.2: 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 Representative that the Medicaid Managed Care Member chooses to act on their behalf (including a Provider), requests a State fair hearing, the MCO must transmit copies of all communication (written and electronic) to the SCDHHS MCO Program liaison concurrent with communication to the Medicaid MCO Member, the Provider, and the SCDHHS hearing officer.

A MCO Member or Representative 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 9.1.6.4 through Section 9.1.9.2, please refer to the contract for all requirements.

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.

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.

Section 9.2.16: MCOs must provide 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 South Carolina 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 through Section 10.3.4, please refer to the contract and to the TPL sections outlined below in this guide for all requirements.

10.4 Cost Avoidance

Section 10.4.1 through Section 10.4.3: Cost avoidance refers to the practice of denying 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 denied 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 SC Healthy Connections Choices 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 Choices 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 SC Healthy Connections Choices Medicaid allowed Copayment, even If the Third Party payer has a Copayment requirement.
Upon request by SC Healthy Connections Choices Medicaid, the MCO must demonstrate that reasonable effort has been made to seek, collect and/or report Third Party recoveries.

SC Healthy Connections Choices 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
- 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.

10.5 Post Payment Recoveries (Benefit Recovery Activities)

Section 10.5.1 through Section 10.5.2.5.1: 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 Subcontractors 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 Subcontractors 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 South Carolina Health Connections Medicaid, the MCOs must demonstrate its compliance with these requirements.

SC Healthy Connections Choices 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 Dispute the decision
- Information on how to file a Provider Dispute
- A request that the Provider submit Claims to the commercial insurance carrier or Medicare if not already done

When Providers choose to Dispute 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 Dispute a copy of a denial from the primary carrier, if available.

10.6 Retroactive Eligibility for Medicare

Section 10.6: 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.

10.8 Third Party Liability Recoveries by the Department

For all cites in Section 10.8 through Section 10.8.2, please refer to the contract for all requirements.

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 Resources, 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 must 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 must 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 must be broken into professional, institutional Claim types and pharmacy Claim types. The report will be uploaded to the MCO's SharePoint monthly library and will contain the following data elements for each Claim type.
    - Professional Claims: Claim paid date, Claim control number, pay to Provider tax id, NPI, name and address, rendering Provider NPI and name, Member date of birth, Member name, beginning and ending dates of service, place of service, procedure code and modifier, procedure code description, units,

diagnosis code(s), carrier code, carrier number, policy holder, policy number, submitted charge, paid amount, amount recovered, denial reason or no response, Provider carrier last date billed, and one hundred and eighty (180) Days from Claim paid Indicator (Y/N)

- Institutional Claims: Claim paid date, Claim control number, pay to Provider tax id, NPI, name and address, attending Provider NPI and name, Member date of birth, Member name, beginning and ending dates of service, place of service, DRG code, bill type, principal diagnosis code, carrier code, carrier number, policy holder, policy number, submitted charge, paid amount, amount recovered, denial reason or no response, Provider carrier last date billed, and one hundred and eighty (180) Days from Claim paid Indicator (Y/N)
- Pharmaceutical Claims: Claim paid date, Claim control number, pay to Provider tax id, NPI, name and address, prescribing Provider NPI and name, Member date of birth, Member name, dispense date, NDC number, prescription number, drug name and description, quantity, Days supply, refill number, carrier code, carrier number, policy holder, policy number, submitted charge, paid amount, amount recovered, denial reason or no response, Provider carrier last date billed, and one hundred and eighty (180) Days from Claim paid Indicator (Y/N)

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 must be broken into open Cases, closed Cases and the number of Case alerts 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, primary injury (diagnosis code), name of liable party, lien amount, date of lien notice sent, name of attorney/insurance company, Carrier Claim #, Case status, settlement amount, recovered amount (if $0 indicate $0 in field), dated closed, and three hundred and sixty five (365) Days from Claim paid Indicator (Y/N)and the following elements for closed Cases: Medicaid Member ID, first name, last name, reason for close, recovered amount and date closed and three hundred and sixty five (365) Days from Claim paid Indicator (Y/N).

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 11.1.6 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, of the managed care contract, Staffing Requirements.

For all cites in Section 11.1.3 through Section 11.1.5, please refer to the contract for all requirements.

Section 11.1.6: The MCO shall promptly perform a preliminary investigation of all complaints and allegations of suspected Fraud and Abuse against Providers or Members. If the findings of a preliminary investigation give the MCO reason to believe that an incident of fraud has occurred by a Provider in the Medicaid program, the MCO must report the allegation to PI and MFCU within one (1) Business Day by using the Provider Notice Form. This form is located on the secure PI website (see the Managed Care Report Companion Guide). Examples of potential fraud indicators can be found under the *Fraud and Abuse Indications* of this Section. The Provider Notice form must 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, related complaints, related data analysis, and any applicable repayment history.

PI will evaluate the allegation and determine whether a Credible Allegation of Fraud (CAF) exists. Refer to Section 11.1.10 of this document. 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.

In Cases where a formal Fraud referral has been made to MFCU and it is documented as stand-down on the MFCU Active Case List on the secure PI website, 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 permission from the

MFCU. 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. If the MFCU determines that it is no longer necessary for the MCO to refrain from review or investigation activities, the MFCU will remove the stand-down from the MFCU Active Cases list uploaded to the secure PI website.

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 reporting between the MCO and the Department.

Fraud and Abuse Indications

The MCO must conduct a preliminary investigation and report suspected Fraud and Abuse. The following are examples of indications of Fraud and Abuse:

A. For Providers/Subcontractors:

Fraud:

- 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 Health 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.
- Material misrepresentation of dates, description of services, the identity of the individual rendering the services, or the Recipient of the services.
- 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.
- 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.

Abuse:

- An excluded/terminated individual, or a Provider not enrolled or contracted with a Plan, bills under another Provider's NPI.
- 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.

  There are significant unexplainable and/or unreasonable spikes in the volume of Claims and reimbursement.

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 MCO Provider or Member form located on the PI secure website (see the Managed Care Report Companion Guide). The form and supporting documents must be saved on the secure PI website. The MCO must complete the MCO Form: Provider Waste & Abuse Referral to report all program integrity related Provider Waste and Abuse. The MCO will notify the DHHS MCO PI Coordinator that the referral has been uploaded. If a Provider who is reported on the Waste and Abuse form is later suspected of fraud, the MCO must complete the Provider Notice Form and notify both the DHHS MCO PI Coordinator and the MFCU Coordinator that the referral has been uploaded to the PI secure website. 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 referral type 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 DHHS MCO PI Coordinator will acknowledge receipt of all referral types within five (5) Business Days by responding to the MCO's email indicating the allegation 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 allegation and any documentation from the MCO's preliminary investigation. If the Provider Notice form is incomplete or does not contain sufficient information to make a determination, it will be returned to the MCO. At its discretion, PI 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 shall communicate to the MCO all Provider exclusions, terminations for cause, providers on prepayment review and payment suspensions for credible allegations of Fraud. These lists are maintained on the secure PI website.

For all cites in Section 11.1.7, please refer to the contract for all requirements.

Section 11.1.8: Refer to Section 11.1.6, MCO Responsibilities and SCDHHS Responsibilities, of this document.

Section 11.1.9: Refer to Section 11.7 of the managed care contract, Cooperation and Support in Investigations, Hearings and Disputes.

Section 11.1.10: Prior to making this determination, the DHHS MCO PI Coordinator will email the MCO a Good Cause Exception (GCE) Request form notifying them of a potential fraud referral for the provider. The MCO may request a Good Cause Exception (GCE) if they believe that enacting a payment suspension against the provider may cause network adequacy issues by completing the GCE Request form and returning it by email to the DHHS MCO PI Coordinator within five business days of receipt. PI may choose not to grant a GCE request even in cases where the MCO has requested one. If PI determines that a CAF exists, all available information supplementing the MCO's allegation will be submitted to the MFCU as part of the formal referral.

Upon a Credible Allegation of Fraud determination, PI will immediately suspend any fee-for-service payments to the Provider in accordance with federal regulations and SCDHHS Policy, unless a GCE has been granted. 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 11.1.16, SCDHHS Reporting, and Section 11.8, Suspension of Payment Based on Credible Allegation of Fraud, of this guide).

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. The DHHS MCO PI Coordinator will notify the MCO via email when a Provider's payments have been suspended by the Department and that the list maintained on the secure PI website has been updated. The MCO will immediately begin actions to place the Provider on suspension within twenty four (24) business hours of the DHHS PI Coordinator's notification to the MCO. The effective date of the suspension must be the effective date provided by the Department. 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, determines 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.

Section 11.1.11: Upon notification by the Department that a Provider has been placed on prepayment review by the Department, the MCO must also place the Provider on payment review to the same extent as the Department. (Refer to Section 11.1.16, SCDHHS Reporting, and Section 11.9, Prepayment Review, of this document).

Notice of Prepayment-

The DHHS MCO PI Coordinator will notify the MCO via email when a Provider has been placed on prepayment review by the Department. and that the list maintained on the secure PI website has been updated. The MCO will immediately begin actions to place the Provider on prepayment review, to the same extent as the Department, but no later than five (5) Business Days. A full prepayment review will be for all submitted claims and not limited by a particular procedure code or random sample. The MCO will document their actions on the Prepayment list located on the secure PI website. The MCO may not remove a provider from prepayment claims review until PI/SURs removes the provider from the Medicaid fee for service prepayment review program. When PI removes a Provider from Prepayment review, the DHHS MCO PI Coordinator will notify the MCO via email that the Prepayment List maintained on the secure PI website has been updated. The MCO will begin actions to remove the Provider from prepayment review. If the MCO opts to maintain the Provider on prepayment review, the MCO will issue a new notice to the provider establishing the criteria for the MCO prepayment review.

DHHS Prepayment claims review process:

To ensure claims presented by a provider for payment meet the requirements of federal and State laws and regulations, and claims payment criteria as defined by program

specific policies and procedures, a provider may be required to undergo prepayment review. Providers under prepayment claims review may be required to submit paper claims with attached documentation for payment consideration. The PI prepayment review process is as follows:

(a) Providers under prepayment claims review shall not be entitled to payment prior to claims review by designated SCDHHS staff. The designated SCDHHS staff will notify a provider in writing when PI/SURs determines the provider will be placed under prepayment claims review. The notice shall contain:

(1) An explanation of PI/SURs' decision to place the provider on prepayment claims review.

(2) A description of the review process.

(3) A description of the claims subject to prepayment claims review.

(4) A list of all supporting documentation the provider must submit with claims subject to prepayment review.

(5) A description of the process for submitting claims with supporting documentation.

(6) The standard of evaluation used to determine when a provider may be removed from prepayment claims review.

(b) Prepayment claims review does not include a review of medical necessity for billed items and/or services.

(c) All clean claims submitted for payment review shall be processed within thirty (30) calendar days of submission.

(d) A provider shall remain subject to the prepayment review process until the provider achieves documented compliance with claims payment criteria. Claims payment criteria is defined as:

(e) The provider achieves three (3) consecutive months with a minimum clean claim rate of eighty percent (80%) and the number of claims submitted each month is no less than fifty percent (50%) of the provider's average monthly submission of Medicaid claims for the three (3) month period prior to the provider's placement on prepayment review, or the last three (3) consecutive months' history of claims submitted.

(f) If a provider fails to submit any claims following placement on prepayment review in any given month, the claims accuracy rating shall be zero percent (0%) for the month no claims were submitted.

(g) If a provider fails to achieve an eighty percent (80%) clean claims rate three consecutive months during the first six months of prepayment claims review. PI/SURs may:

a. continue the provider's enrollment in prepayment claims review for an additional six (6) months and re-evaluate the provider's clean claims rate at the conclusion of the twelve (12) month period; or
b. Initiate provider termination for cause procedures for reason(s) outlined in the South Carolina Medicaid Provider Enrollment Manual located at www.http.//provider.scdhhs.gov and/or for reason(s) listed on the provider's Participation and Payment Agreement.

h. If a provider fails to achieve an 80% clean claims rate for three (3) consecutive months during the provider's additional six (6) months participation under prepayment claims review, PI/SURS will initiate provider termination for cause procedures for reason(s) outlined in the South Carolina Medicaid Provider Enrollment Manual and/or for reason(s) listed on the provider's Participation and Payment Agreement.

(i) If a provider under prepayment claims review voluntarily or involuntarily terminates from the state Medicaid program, the provider may be placed on prepayment claims review upon re-enrollment.

(j) A provider under prepayment claims review may not withhold claims to avoid the claims review process. Any claims for services rendered during the period of prepayment review may still be subject to review prior to payment regardless of the date the claims are submitted for payment.

(k)

DHHS Compliance Monitoring

(a) The designated DHHS staff will evaluate a provider's claims resolution activities to establish the provider's monthly clean claims rate after the provider's sixth (6th) month and twelfth (12th) month under prepayment claims review.

(b) If a provider does not reach the 80% clean claims threshold for three (3) consecutive months, during the first six (6) months of prepayment claims review, the provider will continue on prepayment claims review for an additional six (6) months.

(c) If after twelve (12) months the provider does not achieve the 80% clean claims rate for three (3) consecutive months, the designated DHHS staff will review the provider to:

- Identify potential reason(s) to continue the provider on prepayment claims review, or
- Identify potential reason(s) to terminate the provider for cause from the state Medicaid program (e.g., the provider failed to comply with the terms of the enrollment agreement or the provider failed to comply with the terms of contract with the terms of contract with SCDHHS).

For all cites in Section 11.1.12, please refer to the contract for all requirements.

Section 11.1.13:

- 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 11.1.14 through Section 11.1.15, please refer to the contract for all requirements.

Section 11.1.16: 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 DHHS MCO PI Coordinator will assist in establishing a connection and passwords for MCO staff.

- All Provider and Member referral forms are located on the secure PI website (see the Managed Care Report Companion Guide for the 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 DHHS 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 DHHS 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. The Compliance Officer and the SIU Director will be responsible for validating the accuracy and the timely filing of each report. If inconsistencies are continually noted or failure to meet timely filing, the Compliance Officer and/or SIU Director will be required to file an attestation for a six month period ensuring reporting accuracy.

<u>Quarterly Report</u>

The *Quarterly Report* is based on the State Fiscal Year beginning July 1 and ending June 30. The report is due no later than thirty (30) Calendar Days after the end of each quarter

(Qtr 1, Oct 30; Qtr 2, Jan 30; Qtr 3, April 30; Qtr 4July 30); and uploaded to the appropriate folder within the secure PI website.

The *Quarterly Report* will document activity during the quarter's three month period (Qtr 1, July,Aug,Sept; Qtr 2, Oct,Nov,Dec, Qtr 3, Jan,Feb,Mar, Qtr 4, Apr, May,June) and will document outcomes and results of the MCO's Program integrity efforts. This will include Overpayment activity, Sanctions and Prepayments, Cost Savings, Active Case data, Member fraud and Provider Education. The MCO will be provided with detailed instructions and a reporting format for this information (see the Managed Care Report Companion Guide for the Quarterly Report).

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 that the MCO imposed during the previous month (see the Managed Care 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 on their Monthly Termination/Denial for Cause Report and upload a copy of the Provider's Termination for Cause Letter to the secure PI website.

SCDHHS Reporting of Exclusions, Terminations for Cause and Reinstatements

Within the secure PI website, PI will document their actions taken to exclude or terminate a Provider for cause, or reinstate a Provider that was either excluded or terminated, on the Exclusion and Termination for Cause list and upload copies of the notices/letters. The DHHS MCO PI Coordinator will notify the MCO via email that the PI website has been updated.

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 Dispute is resolved.

SCDHHS Reporting of Suspensions

Within the secure PI website, PI will document their action to suspend a Provider's payments based on a Credible Allegation of Fraud on the Suspension list and upload copies of the notices/letters. The DHHS MCO PI Coordinator will notify the MCO via email that the PI website has been updated.

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 DHHS 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 11.1.10 and Section 11.8, Suspension of Payment Based on Credible Allegation of Fraud, of this guide.

SCDHHS Reporting of Prepayment Reviews

Within the secure PI website, PI will document their action of placing a Provider on prepayment review on the Prepayment list and upload copies of the notices/letters. The DHHS MCO PI Coordinator will notify the MCO via email that the PI website has been updated.

Upon notification by PI of a Provider's prepayment review, either through the list maintained on the secure PI website or the DHHS MCO PI Coordinator's email, the MCO will immediately place the Provider on prepayment review to the same extent as the Department. The prepayment review will be for all submitted claims and not limited by a particular procedure code or random sample. The MCO will document the actions they take against the Provider on the Prepayment list on the secure PI website.

Refer to Section 11.1.11 and Section 11.9, Prepayment Review, of this document.

MCO Annual Strategic Plan

The MCO must provide to PI an annual strategic plan and will be due at a time as determined by the Department and in the form and manner as determined by PI (see the Managed Care Report Companion Guide Annual Strategic Plan).

The annual strategic plan 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 11.1.17: 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 Managed Care 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 PI reviewer will upload the returned letter and the BEOMB Notification on the secure PI website (see the Managed Care Report Companion Guide). The DHHS MCO PI Coordinator will notify the MCO of the referral via email. 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 appropriate referral form (see the Managed Care Report Companion Guide).

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 Provider Form (see the Managed Care Report Companion Guide).

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.)

The MCO may also conduct a special targeted BEOMB job where Members are surveyed to verify whether services were received from a Provider under MCO review. Prior to distribution, the MCO must first request approval from PI for any letter templates. Once approval is granted by PI, the MCO must then upload the letter template to their individual Member Material website in Share Point for the Division of Managed Care approval. The MCO should indicate the date PI granted approval by using the State Approved section on the bottom of the form in the footer section. The MCO must meet the following criteria:

- The MCO must complete the MCO Form: Permissions (see the Managed Care Report Companion Guide), load it to the PI secure website, individual MCO, Shared Documents Permission folder and email the MCO Coordinator.
- The PI Review staff will respond to the permission within five (5) business days and notify the MCO contact person when completed.
- The MCO will generate the BEOMB run and mail the letters to the Members, along with a stamped self-addressed envelope.
- When the Member returns a letter, any response other than a "yes" must be logged to the case for record retention purposes.
- If the case is later referred to PI and MFCU as a fraud referral, all responses that were investigated must be forwarded as part of the referral.

Under a targeted BEOMB run only, the MCO may inquire regarding confidential services for Members age 15 and younger. This request must be identified on the Permission Request. The MCO must obtain specific and individual letter approval for each Permission request in which confidential services are identified.

Section 11.1.18: Refer to Section 11.10, Statewide Pharmacy Lock-In Program (SPLIP), of this document.

For all cites in Section 11.1.19, please refer to the contract for all requirements.

11.2 Compliance Plan Requirements

For all cites in Section 11.2.1 through Section 11.2.9.2, please refer to the contract for all requirements.

Section 11.2.10 through 11.2.11.1: 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), 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 or 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 Provider Notice Form and report this as a Case on their Quarterly Report (see the Managed Care Report Companion Guide).

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.

For all cites in Section 11.2.12, please refer to the contract for all requirements.

Section 11.2.12.1: The Department will provide the form and manner on which the Compliance Plan must be submitted by the MCO. (See the Managed Care Report Companion Guide)

For all cites in Section 11.2.12.2 through Section 11.2.13, please refer to the contract for all requirements.

11.3 CONTRACTOR's Controls

For all cites in Section 11.3, please refer to the contract for all requirements.

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.

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 DHHS MCO PI Coordinator requesting permission from the Department, and specifying the dates and details of the review or audit.

For any review in which the MCO is unable to obtain all of the requested records, the MCO should submit a Request to Terminate referral to PI via the Waste and Abuse referral form for Managed Care Organizations (see the Managed Care Report Companion Guide).

For a desk review, the referral packet must include:

- A records request letter to the Provider, via certified mail with return receipt signature service through the United States Postal Service.
- Documentation that the Provider failed to provide the records as a result of the records request letter.
- Documentation that the MCO conducted a follow-up onsite review with the Provider to obtain the records as a result of the records request letter and that the Provider failed to produce records during the onsite.
- The onsite report detailing the investigative actions.
- Any other documentation to support the request to terminate.

For an onsite review, the referral packet must include:

- Documentation that the MCO conducted an onsite review with the Provider to obtain records and that the Provider failed to produce records during the onsite.
- The records request letter presented to the Provider during the onsite.
- The onsite report detailing the investigative actions.
- Any other documentation to support the request to terminate.

MCO requests to terminate should be submitted to Medicaid Program Integrity via the Fraud and Abuse referral form for Managed Care Organizations (see the Managed Care Report Companion Guide). 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 Managed Care 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 .

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 DHHS 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 Dispute, 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 DHHS 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 11.6.1.2. All Overpayments identified, and collections made must be reported by the MCO PI on its Quarterly Fraud and Abuse report.

For all cites in Section 11.4.6, please refer to the contract for all requirements.

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.

Section 11.5.3.1: Attendance at all PI scheduled meetings is mandatory by both the MCO's Compliance Officer, required in person, and the Program Integrity Coordinator, required in person or via phone. In the event the Compliance Officer has a scheduling conflict, the Program Integrity Coordinator is required in person. The Compliance Officer must notify the DHHS PI Coordinator with any scheduling conflicts.. In addition, the MCO's Compliance Officer, Program Integrity Coordinator, and MCO Program integrity staff will meet at scheduled intervals with DHHS PI staff to discuss Cases and Fraud and Abuse referrals.

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 all cites in Section 11.5.3.2 through Section 11.5.4, please refer to the contract for all requirements.

Section 11.5.5: Refer to Section 11.1.16, Annual Strategic Plan, of this guide.

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.

Section 11.6.1.2: The MCO will report recoveries of Overpayments as a Case on the Quarterly Report.

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

Section 11.6.2.2: The MCO shall remit to the Department with notification to the DHHS 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 11.6.2.2.1 through Section 11.6.3, please refer to the contract for all requirements.

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 11.1.6 of this guide.

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 Provider is listed on the MFCU Active Case List, , the MCO must obtain written permission from MFCU prior to the initiation of any recovery.

For all cites in Section 11.6.4 through Section 11.6.4.6, please refer to the contract for all requirements.

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.

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.

Refer to Section 11.1.10 and 11.1.16 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 Prepayment Review

Refer to Section 11.1.11 and Section 11.1.16 of this document for prepayment review and reporting. Upon notification by PI to the MCO of a Provider placed on prepayment review, the MCO must also place the provider on prepayment review to the same extent as the Department.

11.10 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. Identified Members will be restricted to one pharmacy for a period of two years.

Prior to the restriction and per 42 CFR 431.54 (e)(1)(2) and (3):

- 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. As required by 42 CFR 431 Subpart E, any Medicaid Member who has been notified in writing by the Department of a pending restriction due to mis-utilization of Medicaid services may exercise his/her right to a fair hearing, conducted pursuant to R126-150 et. Seq.

Section 11.10.1: PI will generate a quarterly report that will review all Medicaid Member's Claims for a six (6) month period. The report will look at twenty (20) different weighted criteria as establish by PI based on research; with most of them analyzing the use of pain medications. The report will then assign a score and rank the Member based on that score. It will then select Members for enrollment into SPLIP based on a score determined by the SPLIP. 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

Excludes members with sickle cell disease (ICD9 codes 282.60 thru 282.9 and ICD10 codes D57.00 thru D57.1 and D57.20 thru D57.219 and D57.4 thru D57.819)

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 fifteen (15) 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.

3. **Five or More Controls in Thirty (30) Days** **(3)**

   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.

4. **Two or More ER Visits In Thirty (30) Days and Controlled RX** **(1)**

   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.

   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.

5. **GT 3600 mg Oxycodone HCL in Thirty (30) Days** **(1)**

   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.

   Total mg per prescription = strength * quantity dispensed

Composite Score Measures	Score
6. Two or More Out of State Pharmacies for Controls	**(2)**
Identifies Members with DEA Schedule II-V prescriptions from two (2) or more out of State pharmacies.	
7. Two Controls From Two (2) Pharmacies within Two (2) Days	**(1)**
Identifies Members with two (2) or more DEA Schedule II-V prescriptions dispensed by two (2) different pharmacies on two (2) consecutive Days.	
8. Suboxone within Six (6) Months	**(1)**
Identifies Members with Suboxone prescriptions during the time period of this report. generic_name = 'Buprenorphine Hydrochloride/Naloxone Hydrochloride'	
9. Opioid Within Thirty (30) Days After Suboxone	**(10)**
Identifies Members with an opiod prescription within thirty (30) Days after a Suboxone prescription. Suboxone: generic_name = 'Buprenorphine Hydrochloride/Naloxone Hydrochloride') Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII'	
10. Ten or More Pills Per Day For Controlled RX	**(2)**
Identifies Members with DEA Schedule II-V prescriptions allowing for ten (10) or more pills per Day. Master Form = Capsule or Tablet Qty_Dispensed / Days_Supply >= 10	
11. Pill Count for Controls GT 600	**(2)**
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. Master Form = Capsule or Tablet	

Composite Score Measures	Score
12. Hist of Drug Dependence with Benzo or Opiate RX	**(1)**

Identifies Members with a drug dependence diagnosis code and a Benzodiazapine or Opiate prescription during the six (6) month time period of this report.

Diagnosis code like '304*' - checked all diagnosis codes on professional and hospital Claims

Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII'

Benzodiazepines: Redbook_int_ther_class like '*BENZODIAZEPINES*' and Redbook_dea_class_cd = 'CIV'

13. Hist of Poison Overdose with Benzo or Opiate RX **(1)**

Identifies Members with a poisoning/overdose diagnosis code and a Benzodiazapine or Opiate prescription during the six (6) month time period of this report.

Diagnosis code = '960' to '9799' - checked all diagnosis codes on professional and hospital Claims

Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII'

Benzodiazepines: Redbook_int_ther_class like '*BENZODIAZEPINES*' and Redbook_dea_class_cd = 'CIV'

14. Five or More Prescribers **(0.5)**

Identifies Members with five or more prescribers during the six (6) month time period of this report. All prescriptions included.

15. Two or More Opioid Prescribers **(1)**

Identifies Members with two or more prescribers issuing an opioid prescription during the six (6) month time period of this report.

Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII'

16. Three or More Prescribers for Controlled Substance **(1)**

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.

17. Four or More Pharmacies **(0.5)**

Identifies Members with drugs dispensed by four (4) or more pharmacies during the six (6) month time period of this report. All prescriptions included.

Composite Score Measures	Score
18. Two or More Pharmacies for Controlled Substance	**(1)**
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.	
19. Three or More Cntrl Subst and Drugs of Concern	**(1)**
Identifies Member with three (3) or more drugs between controlled substances (DEA Schedule II-V) and other drugs of concern. Other drugs of concern include tramadol, cyclobenzaprine, methocarbamol, tizanidine and metaxalone. Unique count of generic_name > 3	
20. On Cocktail Reports	**(3)**
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 (30) period.	

The Department can revise these criteria as needed; for example to include current drugs being sought by abusers according to national trends.

The report will also automatically assign a Lock-In Pharmacy for the Member based on the pharmacy they have utilized the most during the six month period.

Section 11.10.1.1: 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.

Section 11.10.1.2: 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 11.10.1.3: 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.

Section 11.10.2 through Section 11.10.2.1.4: Prior to distribution, the MCO must first request approval from PI for any and all modifications to the letter templates by the MCO. Once approval is granted by PI, the MCO must then upload the letter template to their individual Member Material website in Share Point for the Division of Managed Care approval. The MCO should indicate the date PI granted approval by using the State Approved section on the bottom of the form in the footer section.

After a beneficiary is selected for enrollment in the SPLIP, a certified letter will be sent at least 30 days before their Effective Date of enrollment. (template located in the Managed Care Report Companion Guide, unless modifications are approved by Program Integrity) The letter will 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 their sole Provider, they are given twenty (20) Days from the date of the Certified Notification Letter to call and request a pharmacy of their choice. After the Effective Date, all changes will require a request and approval.

Section 11.10.2.2: 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.

<u>Lock-in Schedule</u>

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

For all cites in Section 11.10.2.3, please refer to the contract for all requirements.

Point of Sale:

The Point of Sale system will notify a non-locked 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 11.10.3 through Section 11.10.3.1: The Member will be restricted, or locked into one (or two if approved) pharmacy(ies) where all prescriptions paid by the Medicaid program will be filled for a period of twenty-four (24) consecutive months, two (2) years. The time period will run continuously from the Effective Date to the Termination Date given in the Notification Letter.

Section 11.10.3.2: If the beneficiary leaves the Medicaid program and returns prior to the Termination Date, their enrollment in the LIP will continue until the Termination Date. If the beneficiary moves between Medicaid Plans, they will remain in the program until the Termination Date.

Transfers:

Section 11.10.3.3 – 11.10.3.4: 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 two (2) year time period.
- If the receiving MCO chooses to send a letter to the transferred Member advising them of their 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 two (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 their 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.

Section 11.10.3.5:
Medication Overrides:

There are four (4) conditions for which overrides for locked in Members are allowed:
- The Member is out of town
- The Member's medication needed (strength, quantity, brans, and/or type) is not in stock at the lock-in pharmacy, or the pharmacy has gone out of business
- The selected pharmacy chooses not to serve the Member for cause
- The Member has moved and has not yet changed their lock-in pharmacy

With an override or emergency after regular business hours, weekends, or holidays, the Member will be given a three day (72 hour) supply of the medication. If the Lock-in Pharmacy verifies the medication is not in stock, an override of up to thirty (30) day supply will be approved with a coordinating pharmacy of the Member's choice that can supply the medication.

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.

There are times during a Member's lock in period that a second pharmacy (or even a third) may be warranted. These member 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. Of course, Pharmacy Members can change their lock-in pharmacies when they move to a new location, or their existing pharmacy closes, or the Member has a legitimate complaint with the current Pharmacy's services.

Section 11.10.3.6: 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.

Appeals:

Section 11.10.4 through Section 11.10.4.2: The Member has a right to file an Appeal within thirty (30) Days from the receipt of the Certified Notification Letter if they believe the Claims Medicaid paid in the six (6) month review period contains an error. Per the Notification Letter, the Member has the right to request a detailed claims report with the 6 months of claims data that ranked them for enrollment in the program. 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. (Refer to the contract, Section 9 Appeals). If the Member is enrolled in an MCO, they 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 as a result of the Notification Letter, they will be granted a "stay of action" 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 effort 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, they will be removed from placement into the SPLIP and the reason is documented on the secure PI website. If the Member is selected as a SPLIP candidate in the future, during the placement review process, 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 an 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 a Departmental Appeal, they are removed from placement into the SPLIP and the reason is documented on the secure PI website. If the Member is selected as a SPLIP candidate in the future, during the placement review process, the outcome of this Appeal will be taken into consideration.
   - If the Member loses a Departmental Appeal, 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 Notification Letter WITHOUT Appeal rights.
2. If the Member does not file a Departmental Appeal 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 11.10.5: Removal: Prior to the termination date, the Member will be notified by letter of their 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 a score, they will automatically be re-enrolled in the SPLIP.

11.11 Ownership and Control

Section 11.1 through Section 11.11.1.2.6: 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 Ownership Disclosure Form (Form 1514). 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 non-Benefit/non-direct service Subcontractor's ownership disclosure 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.

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

For all cites in Section 11.12.1 through Section 11.12.5, please refer to the contract for all requirements.

Section 11.12.6: 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 11.12.7: 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 11.1.16, 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 Dispute rights or the timeline for Dispute 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 Monthly Termination Denial for Cause Report (see the Managed Care Report Companion Guide termination report).

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 11.12.8: Refer to Section 11.12.9, MCO Reporting of Provider Terminations or Denials for Cause, of this guide.

Section 11.12.10: 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 11.12.11.1 through Section 11.12.11.4.

Section 11.12.11: The CONTRACTOR must screen all Providers and Subcontractors against the List of Excluded Individuals and Entities (LEIE) website,

For all cites in Section 11.12.11.1 through Section 11.12.13, please refer to the contract for all requirements.

11.13 Prohibited Affiliations with Individuals Debarred by Federal Agencies

For all cites in Section 11.13, please refer to the contract for all requirements.

11.14 Provider Termination / Denial of Credentials

For all cites in Section 11.14 through Section 11.14.2, please refer to the contract for all requirements.

Section 11.14.3: 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.

For all cites in Section 11.14.4, please refer to the contract for all requirements.

11.15 Information Related to Business Transactions

For all cites in Section 11.15, please refer to the contract for all requirements.

11.16 Information on Persons Convicted of Crimes

For all cites in Section 11.16, please refer to the contract for all requirements.

12.0 Marketing Program

12.1 General Marketing Requirements

Section 12.1: 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

Section 12.2 through Section 12.2.10: 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 Medicaid logo. The MCO and SC Healthy Connections Medicaid logos must be proportional in size and location. The MCO must maintain compliance with 42 CFR 438.104. If an individual is seeking choice counseling, the MCO must direct them to SC Healthy Connections Choices. 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 through Section 12.3.1, please refer to the contract for all requirements.

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. <u>Permitted Activities</u>

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 SC Healthy Connections Choices 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), two (2) 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 must 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 must be submitted via SharePoint. SCDHHS will respond to requests within five (5) Business Days.

12.4 Marketing Material Submission Requirements

Section 12.4 through Section 12.4.2: Marketing and educational materials must 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 (Healthy Blue by BlueChoice), 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 through Section 12.5.1.2, please refer to the contract for all requirements.

13.0 Reporting Requirements

13.1 General Requirements

Section 13.1 through Section 13.1.1: 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. Encounter Quality Initiative (EQI) data
3. Healthcare Effectiveness Data and Information Set (HEDIS)
4. Encounter data.

The Managed Care 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 must replace the report in the correct SharePoint library with the following labeling on the report:

"reportname"-corrected MMDDYYYY

The MCO must email their Program liaison notifying them of the corrected report and the new report name and its location in the SharePoint library.

Section 13.1.2: Please see below for a list of all required reports, the Managed Care Report Companion Guide provides additional detail regarding specific format requirements and data elements.

REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
Section 2. CONTRACTOR Administrative Requirements		
1) Organizational Chart	Annually Ad Hoc	Ninety (90) Days after the end of a fiscal year; Within ten (10) Business Days of any change
2) Personnel Resumes	Ad Hoc	Within ten (10) Business Days of any change
Section 3. Eligibility and Enrollment		
1) Call Center Performance	Monthly	Fifteen (15) Calendar Days from the end of the month

REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
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[D]	Monthly	Fifteen (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
6) IMD In-lieu of Stays Greater than 15 days {D}	Annually	TBD
7) PRTF Claim Payment Report	Monthly	The 15th Day of the following month
8) PRTF Prior Authorization Report	Monthly	The 15th Day of the following month
9) Autism Claim Payment Report	Monthly	The 15th Day of the following month
10) Autism Prior Authorization Report	Monthly	The 15th Day of the following month
Section 5. Care Coordination		

REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
1) Care Management	Monthly	Fifteen (15) calendar Days from the end of the month
2) Universal Newborn PA	Ad Hoc As Necessary	As Necessary
Section 6. Networks		
1) Provider Network Assessment	Bi-Annual Ad Hoc	July fifteenth (15th)& January fifteenth (15th); As Necessary
2) Provider Network (Enrollment Broker Submission)[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 sixty (60) Days of date of notice from IRS
2) Patient Centered Medical Homes (PCMH)	Monthly	The fifteenth (15th) Day of the following month
3) Dual Medicare-Medicaid[D]	Monthly	The fifteenth (15th) Day of the following month
4) Deceased Members Receiving Premiums[D]	Monthly	The fifteenth (15th) Day of the following month
5) Manual Maternity Kicker	Monthly	The fifteenth (15th) Day of the following month
6) MCO Withhold[D]	Quarterly	Thirty (30) Calendar Days after the end of a quarter
7) Medical Loss Ratio (MLR)	Annually	Report Due nine (9) months after the end of a fiscal year
8) Annual Rate Survey	Annually	Due date established by the Department when request sent to MCOs annually.
9) RHC Wrap Payments	Quarterly Annually	No later than sixty (60) Days from the end of the quarter ¥; 60 days after the end of a fiscal year.
10) FQHC/ Prospective Payment System (PPS)	Quarterly Annually	No later than sixty (60) Days from the end of the quarter ¥; Sixty (60) Days after the end of a fiscal year.

REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
11) Premium Payment Adjustments[D]	Ad Hoc As Necessary	As Necessary
12) Audited Financial Statement	Annually	By July first (1st)of each year
Section 8. Utilization Management		
1) Drug Utilization Review	Annually	
Section 9. Grievance & Appeal Procedures		
1) Member Grievance Log	Quarterly	Thirty (30) Calendar Days after the end of a quarter
2) Member Appeal Log	Quarterly	Thirty (30) Calendar Days after the end of a quarter
3) Provider Dispute Log	Quarterly	Thirty (30) Calendar Days after the end of a quarter
Section 10. Third-Party Liability		
1) TPL Verification	Monthly	The fifteenth (15th) Day of the following month
2) TPL Cost Avoidance	Monthly	The fifteenth (15th) Day of the following month
3) TPL Coordination of Benefits (COB) Savings	Monthly	The fifteenth (15th) Day of the following month
4) TPL Recoveries	Monthly	The fifteenth (15th) Day of the following month
5) TPL Casualty Cases	Monthly	The fifteenth (15th) Day of the following month
Section 11. Program Integrity		
1) Program Integrity (PI) Fraud and Abuse Member	Ad Hoc As Necessary	As Necessary
2) Provider Notices	Ad Hoc As Necessary	As Necessary

REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
3) Fraud Notification{D}	Ad Hoc As Necessary	As Necessary
4) Complaint Case Notification{D}	Ad Hoc As Necessary	As Necessary
5) SCDHHS Beneficiary Explanation of Medical Benefits (BEOMB)	Ad Hoc As Necessary	As Necessary
6) MCO Payment Suspension	Ad Hoc As Necessary	As Necessary
7) Good Cause Exception (GCE) Form	Ad Hoc As Necessary	As Necessary
8) Permissions Form	Ad Hoc As Necessary	As Necessary
9) Termination Denial for Cause	Monthly	The fifteenth (15th) Day of the following month
10) Quarterly MCO Fraud and Abuse	Quarterly	The thirtieth (30th) day following the close of each quarter
11) Program Integrity (PI) Written Compliance Plan	Annually Ad Hoc	Within ninety (90) Days of contract and annually thereafter; Sixty (60) days prior to proposed change effective date; Submitted directly to Program Integrity
12) Strategic Plan	Annually	
Section 12. Marketing Requirements		
1) Marketing Materials	Ad Hoc As Necessary	As Necessary
Section 13. Reporting Requirements		
1) Claims Payment Accuracy	Monthly	The fifteenth (15th) Day of the following month
2) Graduate Medical Education (GME)	Quarterly	The thirtieth (30th) 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

REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
2) Encounter Submission Summary	Monthly	The fifteenth (15th) Day of the following month
3) Encounter Quality Initiative(EQI)	Quarterly	Within one hundred and twenty-one (121) Days of the end of each calendar quarter
Section 15. Quality Assessment, Monitoring and Reporting		
1) Quality Assessment & Performance Improvement Projects	Ad Hoc As Necessary	As Necessary
2) Population Assessment Report	Annually	Date Set by MCO Quality Committee
3) External Quality Review	Annually	Varies Scheduled annually by EQRO
4) Member Satisfaction Information[ß]		
a) Consumer Assessment of Healthcare Providers and Systems (CAHPS)	Annually	By July first (1st) for previous calendar year
b) Supplemental Member Satisfaction Information	Optional	If conducted, by July first (1st) for previous calendar year
5) HEDIS Reporting	Annually	By July first (1st) for previous calendar year
6) Alternative Payment Model Contracting (APM)	Annually Ad Hoc	By April thirtieth (30th) for previous calendar year. Within three (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 ninety (90) Days of the end of the state fiscal year

Notes:

¥ 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.

[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).

REPORT	FREQUENCY	REPORT SUBMISSION DUE DATE
[M] In addition to the monthly reports submitted to the Department, MCOs submit reports weekly (on Thursdays) to Maximus. ß Refer to Section 15 of the 2014 MCO Contract and Policy & Procedure Guide 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.).		

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 Managed Care Report Companion Guide.

For all cites in Section 13.1.3 through Section 13.1.9.5, please refer to the contract for all requirements.

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.

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 Managed Care Report Companion Guide for the specific attestation that must be submitted for Encounter data.

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 through Section 14.2.2, please refer to the contract for all requirements.

14.3 Claims Data

For all cites in Section 14.3 through Section 14.3.3, please refer to the contract for all requirements.

14.4 Electronic Transactions

For all cites in Section 14.4 through Section 14.4.2, please refer to the contract for all requirements.

14.5 Encounter Data

For all cites in Section 14.5 through Section 14.5.1, please refer to the contract for all requirements.

Section 14.5.2 through Section 14.5.14.2.1: 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 Managed Care 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 or if taxonomy codes are not matched 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 Managed Care 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 record in the non-par Provider file must include the following data elements, HMO-MEDICAID-NUM, PROVIDER-ID-NUMBER, PROVIDER-NAME, PROVIDER-CAREOF (when applicable), PROVIDER-STREET, PROVIDER-CITY, PROVIDER-STATE, PROVIDER-COUNTY, PROVIDER-EIN NUMBER (when applicable), PROVIDER TYPE, PROVIDER SPECIALTY, and PROVIDER NPI. 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 Managed Care 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 Managed Care 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.

For all cites in Section 14.5.15 through Section 14.5.16.1, please refer to the contract for all requirements.

14.6 Submission of Test Encounter Data

For all cites in Section 14.6 through Section 14.6.4.2, please refer to the contract for all requirements.

14.7 Eligibility and Enrollment Exchange Requirements

For all cites in Section 14.7 through Section 14.7.6, please refer to the contract for all requirements.

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.

<u>FQHC</u>

The Department has elected to utilize a Prospective Payment System (PPS) methodology for FQHC Provider reimbursements. Individual PPS rates will be shared with each MCO prior to the start of a new fiscal year. This document will indicate all current encounter reimbursement rates that must be paid for the new fiscal year and the eligible Providers. MCOs and FQHCs through their contractual relationship determine when full payment is made for services rendered by the FQHC. MCOs should only pay for codes that are reflected in the reimbursement methodology chart reflected in the table below.

WRAP PAYMENT METHODOLOGY

EFFECTIVE JULY 1, 2018

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
Ophthalmalogy:	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	J7296
Family Planning Service (separate visit):	J7297
99401-99402	J7298
Postpartum Care:	J7300
59430	J7301
Health Risk Assessment (Foster Care):	J7307
96160, 96161	80305
MNT/Nutritional Counseling/Obesity Initiative:	80307
97802-97803	G0480
	Q2035 - Q2039
Billable as a Behavioral Health Encounter: (2)	Q3014
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.

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

The Medicaid MCO shall submit a report, quarterly, to its SharePoint quarterly library, of all paid Encounter/Claim data, by date of service, for all services rendered by FQHCs. The agency will use this data to review and audit prospective payments to confirm the entire encounter rate was paid to all participating FQHCs. The CONTRACTOR shall submit the data for each FQHC as reflected in the Managed Care Report Companion Guide. 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.

The Department will complete an annual review based on the FQHC's fiscal year end. To complete this process, the following will be required:

1. Within one (1) year and sixty (60) Days of the FQHC's quarterly report, all quarterly wrap-around files for the applicable quarter must be re-run (i.e. updated) in order to capture additional Encounter and Claims data not available when the initial quarterly FQHC report was originally submitted by the MCO.

2. Transmission requirements remain the same as the quarterly submissions. That is, the updated files must 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 review 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 SCDHHS required format found in the Managed Care Report Companion Guide. For your convenience an excel report template is available at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates.

Initial Quarterly FQHC/RHC Report Schedule (Completed in Current Year)		
SERVICE DATES OF QUARTERLY REPORT	**THROUGH PAID DATE**	**REPORT DUE DATE**
January 1 – March 31	Claims Paid through May	May 31
April 1 – June 30	Claims Paid through August	August 31
July 1 – September 30	Claims Paid through November	November 30
October 1 – December 31	Claims Paid through February	February 28
Final Annual Quarter Repeat FQHC/RHC Report (Completed a Year after Initial Report was Submitted to SCDHHS)		
SERVICE DATES OF FINAL QUARTERLY REPORT	**THROUGH PAID DATE**	**REPORT DUE DATE**
January 1 – March 31 (Previous Year)	Claims Paid through May	May 31 (365 days from original submission)
April 1 – June 30	Claims Paid through August	August 31 (365 days from original submission)
July 1 – September 30	Claims Paid through November	November 30 (365 days from original submission)
October 1 – December 31	Claims Paid through February	February 28 (365 days from original submission)

RHC

In order for SCDHHS to satisfy full payment of Rural Health Clinic Providers, the Department reimburses Providers supplemental payments, herein referred to as the wrap-around payments. Wrap-around payments 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 Medicaid 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 Rural Health Clinics on a quarterly basis. The current wrap-around methodology for Rural Health Clinics is reflected in the table below.

RHC WRAP PAYMENT METHODOLOGY

EFFECTIVE JANUARY 1, 2018

RHC	
Allowed CPT Codes (1)	**Exclusions from RHC Encounter Rate (3)**
Billable as a Medical Encounter:	11976,11981
T1015	58300,58301
99201-99205	59025 (TC Modifier)
99212-99215	70000 - 79999 (TC Modifier)
99241-99245	70000 Series - 70% removed for Tech component **(4)**
99381-99385	80000-89999
99391-99395	90378
Add. Codes for Bi-Annual Exams (Adults):	90630
99386	90656
99387	90657
99396	90658
99397	90670
Podiatry:	90620, 90621
Standard E&M codes - see above	90662
Ophthalmalogy:	90672
92002	90673
92004	90685-90688
92012	90707, 90710, 90715, 90716
92014	90732
Chiropractic:	93005
98940-98942	93017
In-Home Services	93041
99341-99345	93225
99347-99350	93325
Domiciliary or Rest Home Services:	93880
99324-99328	93970
99334-99337	97802, 97803
Skilled Nursing Facility Services:	99050
99304-99310	99051
99315-99316	99188
99318	99217 - 99999 *
Family Planning Service (separate visit):	A4264
99401-99402	G0447
Postpartum Care:	H0002
59430	H0004
Health Risk Assessment (Foster Care):	J1050
96160, 96161	J1950
Billable as a Behavioral Health Encounter: (2)	J7296
90791, 90792	J7297
90832-90834, 90836-90838	J7298
90839	J7300
90847, 96101	J7301
T1015/HE	J7307
	Q2035 - Q2039
	Q3014
	S4989
	S9452
	S9470
	*** - 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 RHC encounter service. They are includable in the WRAP "count".

(2) Behavioral Health Services codes that are considered as an eligible RHC 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 RHC 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 RHC encounter service rate and thus should not be separately reimbursed.

(4) The professional component of the 70000 series procedure codes are included in the RHC encounter service rate and thus should not be separately reimbursed.

(5) 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. Note: RHCs are allowed to separately bill obesity services, some of which are group. The group rates are the same as individual rates.

(6) Procedure codes will be reviewed annually to determine if updates are required in either billable encounter codes or excludable services.

The Medicaid MCO shall submit a report, quarterly, to its SharePoint quarterly library, of all paid Encounter/Claim data, by date of service, for all services rendered by RHCs for supplemental payment determination (wrap-around methodology). Services eligible for wrap-around methodology must meet Medicaid Fee-for-Service coverage requirements. The CONTRACTOR shall submit the data for each RHC in the format outlined in the Managed Care Report Companion. This information shall be submitted in the required format 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.

The Department will complete an annual wrap-around reconciliation based on the RHC's fiscal year end. To complete this process, the following will be required:

1. Within one (1) year and sixty (60) Days of the MCO's quarterly RHC wrap-around report, all quarterly wrap-around files for the applicable quarter must 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 submitted by the MCO.

2. Transmission requirements remain the same as the interim RHC wrap-around submissions. That is, the updated files must 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 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 SCDHHS required format found in the Managed Care Report Companion Guide. For your convenience an excel report template is available at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates.

Initial Quarterly FQHC/RHC Report Schedule (Completed in Current Year)		
Service Dates of Quarterly Report	**Through Paid Date**	**Report Due Date**
January 1 – March 31	Claims Paid through May	May 31
April 1 – June 30	Claims Paid through August	August 31
July 1 – September 30	Claims Paid through November	November 30
October 1 – December 31	Claims Paid through February	February 28

Final Annual Quarter Repeat FQHC/RHC Report (Completed a Year after Initial Report was Submitted to SCDHHS)

Initial Quarterly FQHC/RHC Report Schedule (Completed in Current Year)		
SERVICE DATES OF QUARTERLY REPORT	**THROUGH PAID DATE**	**REPORT DUE DATE**
SERVICE DATES OF FINAL QUARTERLY REPORT	**THROUGH PAID DATE**	**REPORT DUE DATE**
January 1 – March 31 (Previous Year)	Claims Paid through May	May 31 (365 days from original submission)
April 1 – June 30	Claims Paid through August	August 31 (365 days from original submission)
July 1 – September 30	Claims Paid through November	November 30 (365 days from original submission)
October 1 – December 31	Claims Paid through February	February 28 (365 days from original submission)

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.

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.

14.10 Data Validation

For all cites in Section 14.10 through Section 14.10.7, please refer to the contract for all requirements.

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 Encounter Quality Initiative (EQI) reports to SCDHHS as well as an annual EQI reporting 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 Managed Care Report Companion Guide. Quarterly EQI reports are due within one hundred and twenty-one (121) Days of the end of each calendar quarter. The annual EQI report will be due the third Friday in January of each year. If there are delays in the MCO's receipt of the previous quarter's EQI analysis SCDHHS will extend the time frame for EQI submission by thirty (30) Days from the MCOs receipt of the EQI results. The following reporting schedules are used:

Quarterly EQI Reporting Schedule*		
SERVICE DATES OF EQI REPORT	**THROUGH PAID DATE**	**EQI REPORT DUE DATE**
January 1 – March 31	Claims Paid through June 30	July 31
January 1 – June 30	Claims Paid through Sept 30	October 31
January 1 – September 30	Claims Paid through December 31	January 31
January 1 – December 31	Claims Paid through March 31	April 30
Annual EQI Reporting Schedule*		
SERVICE DATES OF EQI REPORT	**THROUGH PAID DATE**	**EQI 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 25th of the month in order for SCDHHS and Milliman to have the data for use in EQI analysis.		

Should the due date specified above fall on a weekend or State holiday, the EQI report is due the prior Business Day (i.e., if the Day to submit the EQI report falls on a Saturday, the EQI Report is due the Friday prior at noon (12 PM EST) or if that Friday is a State holiday, the EQI Report is due the previous day (Thursday)). The EQI report and associated definitions are housed in the Managed Care Report Companion Guide.

MCO's must ensure the EQI reports can be verified to a degree of completeness and accuracy of at least 97%. SCDHHS will use the MCO's Encounter data, or other method of data completion verification deemed reasonable by SCDHHS, to verify the completeness and accuracy of the EQI 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 EQI data reporting periods will be on a cumulative year-to-date basis. (i.e., fourth (4th) quarter of calendar year 2012 will be all incurred Claims and Membership for the entire calendar year 2012)

In the event the MCO's EQI reports fail to meet the standards described above, SCDHHS will impose sanctions as described in the contract.

EQI reports must be uploaded to the MCO's SharePoint EQI library. The naming convention of the report must be as follows: (calendar year of report)(calendar quarter of report/annual report)(MCO name)(EQI submission). Example: 2015Q1 ACME MCO EQI 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 through Section 14.11.11.12, please refer to the contract for all requirements.

14.12 Subcontractor(s) and Encounter Data Reporting

For all cites in Section 14.12 through Section 14.12.2.2, please refer to the contract for all requirements.

14.13 Periodic Audits

For all cites in Section 14.13, please refer to the contract for all requirements.

14.14 Future Encounter Data Reporting Requirements

For all cites in Section 14.14 through Section 14.14.2, please refer to the contract for all requirements.

15.0 Quality Management and Performance

15.1 General Requirements

For all cites in Section 15.1 through Section 15.1.5, please refer to the contract for all other requirements.

Section 15.1.6: The MCO must submit annually to SCDHHS a population assessment report written as consistent with population assessment criteria set forth in NCQA's standards and guidelines for Health Plan accreditation. The population assessment should be sent as submitted to the MCO's Quality Assurance Committee. The assessment may be due at a date set by the MCO's Quality Assurance Committee but no more than fourteen (14) months shall elapse between annual submissions of reports. The population assessment shall be submitted no later than December 31st for the prior year. SCDHHS may request submission to SCDHHS other documentation that is also required for NCQA's Health Plan accreditation and will communicate with the MCO reasonable timeframes to correspond with creation of documentation, if needed.

For all cites in Section 15.1.7 through Section 15.1.10.5, please refer to the contract for all other requirements.

15.2 Quality Assurance Committee

For all cites in Section 15.2 through Section 15.2.7, please refer to the contract for all requirements.

15.3 Member Satisfaction Survey

Section 15.3 through Section 15.3.3: 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 separately administered CAHPS surveys:

- CAHPS Health Plan Survey, Adult Version
- CAHPS Health Plan Survey, Child Version (Not the survey that also contains Children with Chronic Conditions questions)
- CAHPS Health Plan Survey, Child Version (with Children with Chronic Conditions questions)

SCDHHS shall provide a Data Submission Protocol to the MCO, on or before April 30th 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
- South Carolina-specific Member-Level Data Files, if applicable
- South Carolina-specific CAHPS Final Report

15.4 Quality Performance Measures

Section 15.4 through Section 15.4.3.1: The MCO is required to collect, report, and submit audited HEDIS measures for South Carolina Medicaid Members. The MCO must include all measures specified for the Medicaid lines of business in the *Technical Specifications for Health Plans Volume 2* of the reporting year. SCDHHS may issue additional guidelines related to measures for any reporting period and reserves the option to require other state-created measures. The MCO is expected to report all measures and must notify SCDHHS at any point the MCO determines that it is unable to report an individual HEDIS measure or set of HEDIS measures. In the event that an MCO does not have the ability to report a HEDIS measure, it should explain the circumstances that prevent the MCO from being able to report that measure Whether or not NCQA requires a specific measure to be reported for health plan accreditation or other purposes of NCQA does not represent an inability on the part of the MCO from reporting that measure.

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. Each MCO must submit a Final Audit Report (FAR) that specifically addresses South Carolina-specific HEDIS data, including the specific supplemental data sources used for South Carolina lines of business and an analysis of medical record review (MRR) medical record review of medical records actually collected on lines of business for South Carolina.

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

Section 15.5 through Section 15.5.2.3: The Department will execute a withhold of capitation rates equal to one and a half percent (1.5%) of the overall sum of rates for the calendar year, 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.

SCDHHS will use Quality Withhold Indices in clinical areas, rather than individual HEDIS measures, to calculate the withhold return. The Quality Withhold Indices for reporting year 2019 (measurement year 2018) and reporting year 2020 (measurement year 2019) are: (1) Diabetes Care, (2) Women's Health, and (3) Pediatric Preventative Care.

SC Medicaid MCO Quality Withhold Indices, Reporting Year 2019/Measurement Year 2018 and Reporting Year 2020/ Measurement Year 2019

HEDIS MEASURE	WEIGHT	HEDIS ABBREVIATION
Index 1: Diabetes		
Hemoglobin A1c (HbA1c) Testing	35%	CDC
HbA1c Poor Control (>9.0%)	25%	CDC
Eye Exam (Retinal) Performed	20%	CDC
Medical Attention for Nephropathy	20%	CDC
Index 2: Women's Health		
Prenatal Care, *Timeliness of Prenatal Care*	30%	PPC
Breast Cancer Screening	25%	BCS
Cervical Cancer Screening	25%	CCS
Chlamydia Screening in Women, *Total*	20%	CHL
Index 3: Pediatric Preventative Care		
Well-Child Visits in the First 15 Months of Life (w15), *6+ Visits*	25%	W15
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	40%	W34
Adolescent Well-Care Visits (AWC)	25%	AWC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: *BMI Percentile, Total*	10%	WCC

Each Quality Withhold index will represent an equal fraction of the MCO's overall withhold, and each Quality Withhold index will be evaluated independently.

Calculating the Index Score:

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

HEDIS SCORE	POINT VALUE
< 10 Percentile	1 Point
10-24 Percentile	2 Points
25-49 Percentile	3 Points
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 reporting year 2019 (measurement year 2018) was evaluated during 2019 using the *Quality Compass* released by NCQA in September of 2018.

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 Withhold Index to calculate the Quality Withhold 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 Withhold 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).

Beginning with reporting year (RY) 2018, which reflects measurement year (MY) 2017, SCDHHS began a process of phasing in a subset of HEDIS measures as a Behavioral Health Quality Index into SCDHHS's quality program. The measures for RY2020 which will be included for consideration of payout of the bonus pool are listed below:

Bonus Only-Behavioral Health Quality Index, RY20/MY19

HEDIS MEASURE	HEDIS ABBREVIATION
Antidepressant Medication Management, *Continuation Phase*	AMM
Follow-up Care for Children Prescribed ADHD Medication, *Initiation Phase*	ADD
Metabolic Monitoring for Children and Adolescents on Antipsychotics, Total	APM
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, *Initiation*	IET

The following rates will be reported as information only in RY2020, MY2019 but may be considered for potential to move to the bonus in future reporting years.

HEDIS MEASURE	HEDIS ABBREVIATION
Prenatal and Postpartum Care, Postpartum Care	PPC
Follow-up After Hospitalization for Mental Illness, 7 Day	FUH
Follow-up Care for Children Prescribed ADHD Medication, Continuation Phase	ADD
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total	APP
Initiation and Engagement of Alcohol and Other Drug Dependence, Engagement, Total	IET
Rating of Health Plan, 9+10, Child Survey	CAHPS
Rating of Health Plan, 9+10, Adult Survey	CAHPS
Getting Needed Care, Always/Usually, Child Survey	CAHPS
Getting Needed Care, Always/Usually, Adult Survey	CAHPS

After all RY2020 rates are reported to SCDHHS as part of annual HEDIS submissions to occur by July 1, 2020, SCDHHS will evaluate results against national benchmarks to determine whether the results continue to indicate an opportunity for improvement and relevancy to SCDHHS's population. The evaluation of RY2020 rates will determine whether the RY2020 results of all of the measures or some portion of the measures of the Behavioral Health Quality Index should remain in the Bonus-Only Stage or become incorporated into a full Withhold stage for RY2021 (MY2020).

Quality Indices, Withhold and/or Bonus Stages RY2021

Once the determination of RY2021 final full withhold and/or bonus-only stages measures is made in 2020, the measures selected to be part of a bonus-only stage or a full withhold stage will be communicated to MCOs. Then RY2021 results corresponding to the selected bonus measures would be used a part of the distribution of quality withholds earned back and/or bonuses distributed in 2020.

It is SCDHHS's intent to continue evaluation of the withhold program each reporting year to determine whether in the following reporting year, bonus-only and full-withhold measures should remain at their respective stages, progress to a later stage in the quality index life cycle, or be retired.

15.6 Alternative Payment Models (APM)

Section 15.6 through Section 15.6.6.2: 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 and will include a listing of amounts associated with each LAN category listed above. 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 SCDHHS, the MCO finds that extenuating circumstances prevented the MCO from achieving the APM target due to SCDHHS 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.

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

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.

The Department may request additional information about value-based contracting.

15.7 NCQA Accreditation Standards and Requirements

For all cites in Section 15.7 through Section 15.7.8.3, please refer to the contract for all requirements.

15.8 External Quality Review (EQR)

Section 15.8 through Section 15.8.3: 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 may be required to 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 Health 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 Health 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 liaison 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

Section 15.9 through Section 15.9.6: 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 through Section 16.1.2, please refer to the contract for all requirements.

16.2 Payment of Capitated Rate

For all cites in Section 16.2 through Section 16.2.2, please refer to the contract for all requirements.

16.3 Notification of Medicaid MCO Program Policies and Procedures

For all cites in Section 16.3 through Section 16.3.2, please refer to the contract for all requirements.

16.4 Quality Assessment and Monitoring Activities

For all cites in Section 16.4 through Section 16.4.3, please refer to the contract for all requirements.

16.5 Fee-for-Service (FFS) Reporting to MCOs

Section 16.5: The Department has a secure file transfer protocol (FTP) site for each MCO. The Department will load Medicaid 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.

16.7 External Quality Review

Section 16.7: 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 Personnel. 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.

16.9 Grievances / Appeals

For all cites in Section 16.9, please refer to the contract for all requirements.

16.10 Training

For all cites in Section 16.10, please refer to the contract for all requirements.

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.

17.2 Termination by Department for Breach

For all cites in Section 17.2 through Section 17.2.5, please refer to the contract for all requirements.

17.3 Termination for Unavailability of Funds

For all cites in Section 17.3 through Section 17.3.2, please refer to the contract for all requirements.

17.4 Termination for CONTRACTOR Insolvency, Bankruptcy, Instability of Funds

For all cites in Section 17.4 through Section 17.4.1, please refer to the contract for all requirements.

17.5 Termination by the CONTRACTOR

For all cites in Section 17.5 through Section 17.5.3, please refer to the contract for all requirements.

17.6 Termination for Loss of Licensure or Certification

For all cites in Section 17.6 through Section 17.6.1, please refer to the contract for all requirements.

17.7 Termination for Noncompliance with the Drug Free Workplace Act

For all cites in Section 17.7 through Section 17.7.1, please refer to the contract for all requirements.

17.8 Termination for Actions of Owners / Managers

For all cites in Section 17.8 through Section 17.8.2.2, please refer to the contract for all requirements.

17.9 Non-Renewal

For all cites in Section 17.9, please refer to the contract for all requirements.

17.10 Termination Process

For all cites in Section 17.10 through Section 17.10.20, please refer to the contract for all requirements.

17.11 Amendments and Rate Adjustments

For all cites in Section 17.11 through Section 17.11.3.2, please refer to the contract for all requirements.

18.0 Audits, Fines and Liquidated Damages

18.1 Audit

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 through Section 18.2.6, please refer to the contract for all requirements.

18.3 Corrective Action Plan

For all cites in Section 18.3 through Section 18.3.4, please refer to the contract for all requirements.

18.4 Sanctions

For all cites in Section 18.4 through Section 18.4.15, please refer to the contract for all requirements.

Section 18.4.16: 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 one hundred and twenty (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(I) 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 twenty-five (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 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 twenty-five (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.

18.5 Plan of Correction Required (Contract Non-Compliance)

For all cites in Section 18.5 through Section 18.5.6, please refer to the contract for all requirements.

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.

19.2 HIPAA Compliance

For all cites in Section 19.2, please refer to the contract for all requirements.

19.3 HIPAA Business Associate

For all cites in Section 19.3, please refer to the contract for all requirements.

19.4 Safeguarding Information

For all cites in Section 19.4 through Section 19.4.6, please refer to the contract for all requirements.

19.5 Release of Records

For all cites in Section 19.5, please refer to the contract for all requirements.

19.6 Confidentiality of Information

For all cites in Section 19.6 through Section 19.6.2, please refer to the contract for all requirements.

19.7 Integration

For all cites in Section 19.7, please refer to the contract for all requirements.

19.8 Hold Harmless

For all cites in Section 19.8 through Section 19.8.7, please refer to the contract for all requirements.

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.

19.10 Notification of Legal Action

For all cites in Section 19.10, please refer to the contract for all requirements.

19.11 Non-Discrimination

For all cites in Section 19.11, please refer to the contract for all requirements.

19.12 Safety Precautions

For all cites in Section 19.12, please refer to the contract for all requirements.

19.13 Loss of Federal Financial Participation

For all cites in Section 19.13, please refer to the contract for all requirements.

19.14 Sharing of Information

For all cites in Section 19.14, please refer to the contract for all requirements.

19.15 Applicable Laws and Regulations

For all cites in Section 19.15 through Section 19.15.14, please refer to the contract for all requirements.

19.16 Independent Contractor

For all cites in Section 19.16, please refer to the contract for all requirements.

19.17 Governing Law and Place of Suit

For all cites in Section 19.17, please refer to the contract for all requirements.

19.18 Severability

For all cites in Section 19.18, please refer to the contract for all requirements.

19.19 Copyrights

For all cites in Section 19.19, please refer to the contract for all requirements.

19.20 Subsequent Conditions

For all cites in Section 19.20, please refer to the contract for all requirements.

19.21 Incorporation of Schedules / Appendices

For all cites in Section 19.21, please refer to the contract for all requirements.

19.22 Titles

For all cites in Section 19.22, please refer to the contract for all requirements.

19.23 Political Activity

For all cites in Section 19.23, please refer to the contract for all requirements.

19.24 Force Majeure

For all cites in Section 19.24 through Section 19.24.2, please refer to the contract for all requirements.

19.25 Conflict of Interest

For all cites in Section 19.25, please refer to the contract for all requirements.

19.26 Department Policies and Procedures

For all cites in Section 19.26, please refer to the contract for all requirements.

19.27 State and Federal Law

For all cites in Section 19.27, please refer to the contract for all requirements.

19.28 CONTRACTOR'S Appeal Rights

For all cites in Section 19.28, please refer to the contract for all requirements.

19.29 Collusion / Anti-Trust

For all cites in Section 19.29, please refer to the contract for all requirements.

19.30 Inspection of Records

For all cites in Section 19.30, please refer to the contract for all requirements.

19.31 Non-Waiver of Breach

For all cites in Section 19.31 through Section 19.31.2, please refer to the contract for all requirements.

19.32 Non-Assignability

For all cites in Section 19.32, please refer to the contract for all requirements.

19.33 Legal Services

For all cites in Section 19.33, please refer to the contract for all requirements.

19.34 Attorney's Fees

For all cites in Section 19.34, please refer to the contract for all requirements.

19.35 Retention of Records

For all cites in Section 19.35 through Section 19.35.3, please refer to the contract for all requirements.

DEFINITION OF TERMS

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

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Beneficiary practices that result in unnecessary cost to the Medicaid Program.

Action – The denial or limited authorization of a requested service, including the type or level of service;

- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the state;
- The failure of the CONTRACTOR to process Grievances, Appeals or expedited Appeals within the timeframes provided in this contract; or

For a resident of a rural area with only one Medicaid Managed Care Organization (MCO), the denial of a Medicaid Member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the CONTRACTOR's network.

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 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.

Alternative Payment Model (APM) - A form of payment reform that incorporate Quality and total cost of care into the reimbursement for medical services, as opposed to paying Claims with a traditional Medicaid Fee For Service Rate.

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 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 on a Members behalf through a written document signed by the Applicant or Member, or through another legally binding format subject to applicable authentication and data security standards. Legal documentation of authority to act on behalf of an Applicant or Member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of the Applicant's or Member's

signature.

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

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 – A universal Claim form, required by CMS, to be used by non-institutional and institutional providers that do not use the UB-04.

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.

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.

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.

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.

Copayment – Any cost sharing payment for which the Medicaid MCO Member is responsible for in accordance with 42 CFR § 447.50.

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.

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 indications 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.

Days – Calendar Days unless otherwise specified.

Department – For the purposes of this contract, the term "Department" is used in reference to the South Carolina Department of Health and Human Services (SCDHHS).

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).

DHEC – South Carolina Department of Health and Environmental Control.

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.

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.

Disenroll/Disenrollment/Disenrolled – 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.

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

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

Early and Periodic Screening Diagnosis and Treatment (EPSDT)- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

- **Early:** Assessing and identifying problems early
- **Periodic:** Checking children's health at periodic, age-appropriate intervals
- **Screening:** Providing physical, mental, developmental, dental, hearing, vision, and other Screening tests to detect potential problems
- **Diagnostic:** Performing diagnostic tests to follow up when a risk is identified, and
- **Treatment:** Control, correct or reduce health problems found.

States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and Medically Necessary services needed to correct and ameliorate health conditions, based on federal guidelines.

Eligible or Eligibles – 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 Financial Participation (FFP) – Any funds, either title or grant, from the federal government.

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

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 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 Department of Insurance and qualified by CMS.

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 Effectiveness Data and Information Set (HEDIS) – Standards for the measures are set by the NCQA.

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

High-Risk Member – The High-Risk Members do not meet Low- or Moderate-Risk criteria.

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 Hospital Swing Beds or Administrative Days.

Key Personnel – Individuals employed by the CONTRACTOR who have authority and responsibility for planning, directing and controlling CONTRACTOR activity**.**

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.

Low-Risk Member – The Low-Risk Members do not meet Moderate- or High-Risk criteria.

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).

Managed Care Policy and Procedure Guide – A supplementary document to the managed care contract. The document lays out specific procedural instructions that need to be followed when providing services to Medicaid Recipients.

Managed Care Report Companion Guide – A supplementary document to the managed care contract. The document lays out specific reporting requirements and templates that need to be followed when providing services to Medicaid Recipients.

Management Service Agreements – A type of Subcontract with an entity in which the CONTRACTOR delegates some or all of the comprehensive management and administrative services necessary to fulfill the CONTRACTOR's obligations to the Department under the terms of this contract.

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 – As defined in 42 CFR 438.104, materials that (1) are produced in any medium, by or on behalf of an MCO and (2) can reasonably be interpreted as

intended to market the MCO 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 Guide and Provider Subcontracts, a Medicaid MCO Member shall also include parents, guardians, or any other persons legally responsible for the Member being served.

Medical Management - Medical Case Management is a collaborative process that facilitates recommended treatment plans to assure the appropriate medical care is provided to Medicaid Members. It refers to the planning and coordination of health care services appropriate to achieve the goal of medical rehabilitation.

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

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".

Moderate-Risk Member – The Moderate-Risk Members do not meet Low- or High-Risk criteria.

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 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 – A Provider 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.

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

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 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.

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.

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.

Redetermination- A person who has been determined Eligible to receive services as provided for in the SC State Plan for Medical Assistance under Title XIX after formerly not

being Eligible under the SC State Plan for Medical Assistance under Title XIX.

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.

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.

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.

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.

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 Security Administration's Death Master File (SSDMF) – The SSA Limited Access Death Master File is used by leading government, financial, investigative, credit reporting organizations, medical research and other industries to:

a) Verify death as well as to prevent Fraud, and

b) Comply With the USA Patriot Act.

Access to the Death Master File is restricted and requires all users to complete the following certification form. All questions and concerns regarding the certification form, should be directed to NTIS at subscriptions@ntis.gov or 1-800-363-2068. The Limited Access Death Master File (DMF) from the Social Security Administration (SSA) contains over 86 million records of deaths that have been reported to SSA. This file includes the following information on each decedent, if the data are available to the SSA:

- Social security number,
- Name,
- Date of birth, and
- Date of death.

The SSA does not have a death record for all persons; therefore, SSA does not guarantee the veracity of the file. Thus, the absence of a particular person is not proof this person is alive.

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

South Carolina Healthy Connections Choices- South Carolina Medicaid's contracted Enrollment broker for Managed Care Members.

South Carolina Healthy Connections Medicaid- The Title XIX program administered by the Department, also known as South Carolina Medicaid.

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 agr
eement 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 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 – 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.

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
If you live in one of these counties call: **1-866-910-7688** **Region 1** Abbeville Anderson Cherokee Edgefield Greenville Greenwood Laurens McCormick Oconee Pickens Saluda Spartanburg	If you live in one of these counties call: **1-866-445-6860** **Region 2** Aiken Allendale Bamberg Barnwell Calhoun Chester Clarendon Fairfield Kershaw Lancaster Lee Lexington Newberry Orangeburg Richland Sumter Union York	If you live in one of these counties call: **1-866-445-9954** **Region 3** Beaufort Berkeley Charleston Chesterfield Colleton Darlington Dillon Dorchester Florence Georgetown Hampton Horry Jasper Marion Marlboro Williamsburg