



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



July 1, 2012

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MANAGED CARE ORGANIZATION PROGRAMS

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

1.0 INTRODUCTION

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

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

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

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

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

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

The Department of Managed Care, located within the Division of Managed Care, Bureau of Managed Care and Medical Support Services, 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 chapter. MCOs in need of assistance to locate, clarify, or interpret medical or Program Policy should contact the Department of Managed Care at the following address:

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

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

The SCDHHS, at its discretion, may institute a Corrective Action Plan (CAP) against an MCO. A designated period to allow for public comments will occur prior to any CAP being implemented.

The SCDHHS will provide written notification to a service provider or Contractor which it places under a CAP. Further, to ensure transparency of operations, SCDHHS will make a public announcement when it places a service provider or Contractor under a CAP. The announcement will, at a minimum, be made via a Provider Bulletin, media release and or publication on the SCDHHS website.

2.0 THE CONTRACT PROCESS

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

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

Potential MCOs who are not currently licensed as domestic insurers in the state of South Carolina should contact the SCDOI, Office of Company Licensing, to begin the

process. Licensing information may be obtained by calling (803) 737-6221, or through the SCDOI's Web site, www.doi.sc.gov. The SCDHHS Division of Managed Care should not be contacted prior to obtaining a Certificate of Authority from SCDOI.

The qualified potential MCO should enclose a copy of the SCDOI Certificate of Authority with a letter requesting inclusion, participation, and enrollment in the MCO Program, and should indicate if the MCO wishes to operate under the ethical limitations section of the MCO contract. If the MCO wishes to operate under the ethical limitations section, the letter must include a copy of the company's ethical limitations statement and/ or policy. The letter should be addressed to:

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

Upon receipt of the letter and the Certificate of Authority, SCDHHS will verify the license and the date of issue with the SCDOI. SCDHHS will contact the potential MCO and request the following information sent in an application packet:

1. Business Plan
2. Ownership Disclosure (regardless of percentage of ownership)
3. Board Member Names and Qualifications
4. Officer Names and Qualifications
5. SCDOI Certificate of Authority
6. Financial Statements (bank account, line of credit, loans)
7. 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 application packet, SCDHHS will develop a project plan to include all elements potential MCOs will need to become a contracted SC Medicaid Managed Care Provider. Included with the project plan will be the requirement of the MCO to coordinate with the SCDHHS Division of MMIS to establish connectivity with the SCDHHS information system(s).

At the appropriate time, SCDHHS will authorize its External Quality Review Organization (EQRO) to begin a readiness review of the MCO's South Carolina operation. 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.

Following the EQRO review, SCDHHS will mail an enrollment package to the potential MCO or vendor at the appropriate time. The enrollment package will contain the following:

1. Two (2) copies of the contract
2. Enrollment Form (DHHS Form 219-HMO)
3. Minority Business Form
4. Disclosure of Ownership & Control Interest Statement Form SCDHHS 1513 (02/09)
5. Form W-9, Taxpayer Identification Number and Certification
6. Drug Free Workplace Form
7. EFT Authorization Form
8. Certification Relating to Restrictions on Lobbying
9. Copy of the MCO Policy and Procedures Guide

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

- All contracts and amendments have been prior approved by SCDHHS
- All contracts have been properly signed and have an effective date
- All contracts include approved hold harmless language
- All contracts cover the services specified in the county 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.

Information on reports, spreadsheets, and file layouts is located in the MCO Reports Companion Guide housed on the SCDHHS Web site at www.scdhhs.gov.

2.1 Required Submissions

The following items and/or documents must be submitted by the MCO with the signed signature pages of the official contract. The contract sections indicated are intended as a guide only and may not be the only contract requirements related to the required submissions listed. This information is being provided as a guide only and does not relieve the MCO from complying with **all** appropriate contract requirements for each required submission.

A. Organizational Requirements

1. A Certificate of Authority as approved and licensed by the South Carolina Department of Insurance to operate as a domestically licensed Managed Care Organization (MCO). (See Contract Section 2.)
2. A copy of the Ownership and Control Interest Statement [Form CMS-1513 (02/09)] and a copy of your organizational documents (partnerships, incorporations, etc.) (See Contract Section 10)
3. Certification statements (included with enrollment packet)
4. A copy of any current or pending administrative legal action or Grievance filed by the Subcontractor or the Medicaid MCO Member, including the dates of initiation and resolution. (See Contract Section 5.)
5. A copy of any current or pending administrative legal action or Grievance of person(s) convicted of criminal offense, including the dates of initiation and resolution
6. A list of staff liaisons. Please include the name, title, and telephone number of the designated individual for the following (See Contract Section 3.).
 - Liaison Staff Contact
 - Medical Director Contact
 - Senior Management Contact
 - QA Contact
 - Reporting Contact

B. Provider Requirements (Provider Network List)

1. A listing of network Provider and/or Subcontractors (only executed contracts) (See Contract Section 4)
2. A copy of any Notice of Intent of Subcontractors Termination
3. A copy of model Subcontracts for each healthcare Provider type (limited to six (6) specified contract types)

The MCO must provide documentation that it has checked the Excluded Parties List Service administered by the General Services Administration. This requirement can be accomplished by including a short written statement to the record/file that is dated and states the Excluded Parties list has been checked on a specific date and the findings contained.

C. Service Delivery Requirements

1. A description of expanded services, if any, offered for Medicaid MCO Members. (See Contract Section 4)
2. A listing of the service area(s) as approved by SCDOI and Medicaid service area (if different). (See Contract Section 4)
3. A copy of the referral/monitoring process, Policies and procedures, as well as forms, process for in/out of plan services to include Medicaid fee-for-service referrals. (See Contract Section 4)
4. A copy of written emergency room service Policies, procedures, protocols, definitions, criteria for authorization/denial of emergency room services and triage system. (See Contract Section 4 and see Quality Assurance and Utilization Review section of this document)
5. A copy of PCP selection procedures and forms. (See Contract Section 4.)

D. Quality Assessment and Performance Improvement

A copy of Quality Assessment and Performance Improvement (QAPI) Program per 42 CFR 438 requirements (written description, credentialing, disciplining, and recredentialing Policies and procedures).

E. Marketing

1. The MCO's maximum Medicaid MCO Member Enrollment (projected) levels. (See Contract Section 6.)
2. A copy of the MCO's written marketing plan and materials, including evidence of coverage and Enrollment materials, Recipient education materials, member handbook, Grievance materials, a sample or copy of the Medicaid MCO Member ID card(s) and advertising materials. (See Contract Section 7 and Marketing, Member Education and Enrollment section of this document.)

F. Reporting

Proof of data transfer capabilities verified in writing by SCDHHS and the MCO. Proof shall constitute the successful transfer of test files via EDI and meet SCDHHS file format requirements. SCDHHS must agree to any modifications (format, claims or encounter submission reports etc.) prior to MCO implementation.

2.2 Readiness Review

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

2.3 Provider Network Adequacy Determination Process

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

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

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

Services must be accessible as described in the Proximity Guidelines. Generally, this is within a thirty (30) mile radius from a Medicaid MCO Member's residence for PCPs. Specialty care arrangements must meet normal service patterns as determined by

SCDHHS. Exceptions may be made if the travel distance for medical care exceeds the mileage guidelines.

SCDHHS, at its discretion and at any time it deems necessary, may request the MCO to submit their currently approved counties for redetermination. SCDHHS reserves the right to implement a Corrective Action Plan (CAP), or begin the network termination and transition plan as outlined in Section 13.0 of this P&P Guide should it be determined the MCO is not adequately meeting the needs of its Medicaid MCO Members within a given county.

2.4 Contracts for Subcontractors

If the MCO decides to Subcontract service provision, it must have a properly executed contract with the Provider of those services. The contract must be for at least 12 months (one year). SCDHHS will not accept Letters of Agreement (LOA), Memorandum of Understanding (MOU) or any variations of these types of agreements. Single case agreements are not prohibited under this section.

2.5 Payment of Non-Participating Pediatric Providers

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

In the interest of Continuity of Care, MCOs are to compensate these non-participating providers, at a minimum, the Medicaid fee-for-service rate on the date(s) of service until such time the infant can be served by a participating physician, or can be transferred to a health plan in which the pediatrician is enrolled. A Universal Newborn Prior Authorization (PA) form has been developed and implemented as a means of facilitating the PA process for services rendered in an office setting within sixty (60) days following hospital discharge. This form is located on the SCDHHS Web site under Reference Tools in the Managed Care section.

2.6 Changes to Approved Model Subcontracts

Should an MCO modify a previously approved Provider model Subcontract it must submit a redline version of the Subcontract to SCDHHS for approval prior to execution by either party. The submission must be electronic and in the document format required by SCDHHS. The electronic redline contract submission must contain the following information:

- An electronic redline version of the Subcontract showing all requested language changes and deviations from the approved model

- Headers, completed reimbursement page, completed information of Subcontract facility(ies) including locations, complete Provider information including location(s), attachments or amendments, and the projected execution date of the Subcontract
- Covered Programs (*i.e.*, Healthy Connections)
- Footer information containing the original model Subcontract approval number and date
- All reimbursement must be included in both the redline and final black-line submitted Subcontracts

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

MCOs are required to update their contract boilerplate on an annual basis and/or after changes have been made to the SCDHHS contract. These updates must be submitted to SCDHHS for approval within forty-five (45) calendar days after the new contract or amendment with SCDHHS has been signed by the MCO.

2.7 New Boilerplate Subcontract

The South Carolina Department of Health and Human Services (SCDHHS) has developed a standardized Subcontract boilerplate for Providers who contract with Managed Care Organizations (MCOs). The SCDHHS Subcontract boilerplate is broken down into four articles.

- **Article I** will encompass all SCDHHS required language. (Language in this section cannot be altered, modified or changed by either the Provider or MCO.)
- **Article II** includes the scope of services being provided by the Provider.
- **Article III** lists the facilities and or additional Providers who are attached to the contract.
- **Article IV** is the financial and business arrangement negotiated between the Provider and the MCOs.

Effective February 1, 2012, MCOs will begin implementation of the boilerplate Subcontract for all new Providers and existing Providers as contracts are renewed.

MCOs must submit new subcontract boilerplates to SCDHHS no later than December 15, 2011. Providers or MCOs may not alter the language in Article I. The language contained in the remainder of the MCO subcontract is negotiable by either party.

Subcontracted Providers cannot appeal to the State Fair Hearing process for claims and or payment resolution unless it is in support of Member Grievance. Providers must obtain a Member's written consent prior to representing the Member at a State Fair Hearing.

2.8 Contract Update Process

MCOs must update existing operating (signed) contracts to current contract standards no less than every five years from their effective date. MCOs will identify the contracts in need of updating and provide a list to their SCDHHS program manager quarterly. MCOs are allowed no more than twelve (12) months to complete this update process and report the final disposition to SCDHHS.

In 2010, all contracts identified as being five (5) years old and beyond the one (1) year negotiation period will be out of compliance with SCDHHS contract standards. All contracts identified as being non-compliant in 2010, must be replaced by the end of 2011. Failure to comply will result in corrective actions, to include sanctions.

Any contracts identified as being five (5) years old in 2011 and subsequent years must be replaced within the same calendar year. Failure to comply will result in corrective actions, to include sanctions.

2.9 MCO Communications to Providers

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

Should the MCO amend any type of subcontract with a contracted provider, the amendment must be approved by SCDHHS at least thirty (30) days prior to the amendment being sent to the provider.

2.10 Provider County Network Approval Process

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 the Department of Managed Care using the same criteria.

The MCO submits its network listing for a specific county to the Department of Managed Care, requesting approval to commence Medicaid MCO Member Enrollment in that county. The MCO is to follow the Network Provider and Subcontractor Listing Spreadsheet requirements found in the MCO Reports Guide located on the agency Web site – www.scdhhs.gov, along with the Model Attestation Form found at the end of this section. The model attestation must be executed and provided with all new and/ or resubmitted Network Provider and Subcontractor Listing Spreadsheets.

The MCO is responsible for ensuring that all enrolled Providers are eligible to participate in the Medicaid Program. If a Subcontractor is **not** accepting new Medicaid MCO Members, the Subcontractor cannot be listed on the Spreadsheet. Additionally if a PCP or specialist does not have admitting privileges to at least one of the contracted Hospital (s) listed on the Spreadsheet, the MCO must provide a detailed description of the mechanisms that will be used to provide services to Medicaid MCO Members. SCDHHS reserves the right to disapprove any Provider Network submission based on the information provided. The MCO shall check the LEIE and other applicable federal reporting sources to ensure compliance with the MCO contract. (See Contract Section 5)

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

1. Using the Network Provider and Subcontractor Listing Spreadsheet and other appropriate Provider listings, the Department of Managed Care examines the listing for the inclusion & availability of Provider types for the following categories of service: Ancillary, Hospital, Primary Care and Specialists.
2. Network adequacy is determined by SCDHHS and based on the MCO's projected maximum Medicaid MCO Member Enrollment for a specific county, member proximity guidelines to Providers, and historical service patterns.

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

- Status "1" = Required Provider; Requires an executed contract for a period of no less than one (1) year
- Status "2" = MCOs are not required to contract with this Provider type (RHC/FQHC) unless this Provider type is in support of network approval.

- Status “3” = Attestation; MCOs will provide services through any means necessary. While MCOs may attest to status “3” services, a contract is not required when MCO reimbursement is at or above the established Medicaid fee schedule for the date of service. A contract is required should an MCO choose to compensate at a rate less than the Medicaid fee schedule for the date of service.
 - Status “4” = Additional services provided for and reimbursed by the MCO that are not available under Medicaid. Such services must comply with the terms of the Policies and procedures, and contract between SCDHHS and the MCOs. MCOs must have contracts to support all Additional Services. Before an MCO may offer these services, prior approval is required from the SCDHHS.
3. The goal is to ensure the approval of a network that will guarantee appropriate level of access to care for Medicaid MCO Members.
 4. If the submitted Provider network is determined not to be adequate by the Department of Managed Care, the submitted Provider network, documentation and reasons for denial of the county by the Department of Managed Care is shared with management at the division, bureau and executive levels.
 5. If SCDHHS determines that a network is not adequate, the MCO will be notified, in writing (either electronic or paper format), the network is not approved and the specific reasons for that decision. The MCO may resubmit this network for consideration once the reasons for disapproval have been corrected.
 6. If SCDHHS determines the MCO has submitted an adequate network for a county, the Department of Managed Care will approve the network, set the effective date for enrollment and notify the MCO in writing. SCDHHS will also notify the MMIS system to modify the “counties served” indicator in the Provider file to allow Medicaid MCO Member enrollments to be processed. Also, both the enrollment and transportation brokers are informed of the addition of approved counties.

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

SCDHHS may modify the auto assignment (please see appendix 6 at the end of this guide), or Medicaid MCO Member choice processes, at its discretion. If an MCO requests to limit auto-assignment and/or Medicaid MCO Member choice, SCDHHS will re-evaluate the adequacy of the county network. As a result of this review, SCDHHS reserves the right to rescind its approval of the affected county(ies) and institute a transition plan to move the MCO’s Medicaid Members to other managed care options. The affected MCO will pay all cost associated with the transition plan.

7. SCDHHS reserves the right to perform a review (on-site or off-site), announced or unannounced. Upon request MCOs are required to provide access to electronic copies of the Provider Subcontracts, including any applicable approved amendments, credentialing, Hold Harmless Agreements and any other documentation SCDHHS deems as necessary for review. Access to requested documentation must be provided to the SCDHHS within one (1) hour following the request.

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

2.11 Network Provider and Subcontractor Listing Spreadsheet

NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE	STATUS	SCDHHS COMMENTS
ANCILLARY SERVICES:		
Ambulance Services	3	
Durable Medical Equipment	1	
Orthotics/Prosthetics	1	
Home Health	1	
Infusion Therapy**	1	Follow proximity guidelines for specialists
Laboratory/X-Ray	1	
Pharmacies*	1	Follow proximity guidelines for Primary Care Providers
Hospitals	1	Follow proximity guidelines for specialists
PRIMARY CARE PROVIDERS:		
Family/General Practice	1	
Internal Medicine	1	
RHC's/FQHC's	2	Not required but may be utilized as a PCP provider
Pediatrics	1	

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NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE	STATUS	SCDHHS COMMENTS
OB/GYN	1	
Allergy/Immunology	1	
Anesthesiology	3	

NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE		
SPECIALISTS		
Audiology	3	
Cardiology	1	
Chiropractic	3	
Dental	4	
Dermatology	1	
Emergency Medical	3	
Endocrinology and Metab	1	
Gastroenterology	1	
Hematology/Oncology	1	
Infectious Diseases	1	
Licensed Independent Social Worker	1	
Licensed Professional Counselor	1	
Licensed Marriage & Family Therapist	1	
Neonatology	3	
Nephrology	1	
Neurology	1	
Nuclear Medicine	3	
OB/GYN	1	Serving as PCP for pregnant women, follow Proximity Guidelines for Primary Care Providers
Ophthalmology	1	
Optician	4	

NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE		
Optometry	1	
Orthopedics	1	
Otorhinolaryngology	1	
Pathology	3	
Pediatrics, Allergy	3	
Pediatrics, Cardiology	3	
Podiatry	3	
Psychiatry (private)	1	
Psychologist	1	
Pulmonary Medicine	1	
Radiology, Diagnostic	3	
Radiology, Therapeutic	3	
Rheumatology	1	
Surgery - General	1	
Surgery - Thoracic	3	
Surgery - Cardiovascular	3	
Surgery - Colon and Rectal	3	
Surgery - Neurological	3	
Surgery - Pediatric	3	
Surgery - Plastic	3	
Urology	1	
Private Physical Therapy	1	
Private Speech Therapy	1	
Private Occupational Therapy	1	
Hospital Based Physical Therapy***	1	
Hospital Based Speech Therapy***	1	
Hospital Based Occupational Therapy***	1	
Long-Term Care	3	MCO responsibility begins once the Medicaid MCO Member has been approved for, and

NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET		
SERVICE		
		admitted to the LTC facility. If the Medicaid MCO Member stays in the facility for 90 consecutive days, the Medicaid MCO Member will be disenrolled from the MCO at the earliest opportunity by SCDHHS. The MCO financial responsibility will not exceed 120 days total.
Status	1 = Required 2 = Not required unless serving as PCP for the county 3 = Attestation 4 = Attest, if offered	
Proximity Guidelines		
*Primary Care Providers should be within a maximum of 30 miles of the Medicaid MCO Member's place of residence		
**Specialty Care Providers should be within a maximum of 50 miles of the Medicaid MCO Member's place of residence		
SCDHHS considers all the facts and circumstances in reviewing Subcontracts and networks. SCDHHS may grant exceptions to its' stated criteria on case-by-case basis.		
***Therapies are in-patient or out-patient based.		

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

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

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

MCOs must:

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

MCOs must:

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

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

3. Members shall not be automatically assigned to a NP; however, members may choose a NP to provide the health care services allowed with their scope of services.
 - NPs submitted on provider files to the enrollment broker must be coded to allow member choice only

Attestation of Provider Network Submission

(Company Letter Head)

Attestation of Provider Network Submission

For _____ Count(y)(ies)

Date _____

I, _____, as an officer (Title) for (Name of Company), do hereby attest that the information provided on the Provider Network Listing Spreadsheet for _____ Count(y) (ies) is (are) accurate, true, and complete.

Based on the required submissions for review and approval of a Managed Care Organization's (MCO) network, I attest that each contracted Provider has been properly credentialed as provided in the Contract between our organization and SCDHHS and the MCO Policy and Procedure Guide. I further attest that the necessary information for these Providers has been loaded into our organization's system prior to providing services to South Carolina Medicaid MCO Members. Additionally, I attest that the following requirements have been met:

- All contracts and amendments utilize a model Subcontract approved by SCDHHS, or any modifications to the model Subcontract have been approved by SCDHHS prior to execution,
- All contracts have been properly signed, dated and executed by both parties,
- All contracts are in effect for a minimum of one year (12 months) and may not exceed a maximum total of five (5) years,
- All Provider files contain information regarding hospital privileges (if appropriate), credentialing, and a list of group practice members.

In addition to the services provided through its contracted network, (health plan name) will provide access to medically necessary **covered services** through any necessary means, consistent with its contract with SCDHHS, including out-of-network Providers; these alternative arrangements include, but are not limited to, single case agreements.

I understand that should SCDHHS determine the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to sanctions and/or fines as outlined in Section 13.5 of the contract.

Signature/Title

Date

3.0 NETWORK TERMINATION / TRANSITION PROCESS

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

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

1. SCDHHS Managed Care staff receives verbal and written notification from the MCO, along with a copy of the termination letter from the essential Provider(s). A copy of the termination letter must be provided to SCDHHS within twenty-four (24) hours of receipt of essential Provider(s)'s intent to terminate its contract(s) with the MCO. Any termination must be effective at the end of the month of termination since the MCO has been compensated for a full month of services for each Medicaid MCO Member.
2. SCDHHS Managed Care staff receives verbal or written notification directly from essential Provider(s) of its intent to terminate its contract with the MCO. SCDHHS will notify the MCO in writing (by letter or e-mail) within twenty-four (24) hours of receipt of the essential Provider's intent to terminate.
3. During the annual review of the Provider Network Listing Spreadsheet, or during a review conducted at the discretion of SCDHHS, SCDHHS determines the MCO does not meet the network adequacy standards contained in the MCO Contract and/or this Guide.
4. The MCO may initiate a voluntary request to terminate a county(ies) (see Section 3.1 of this Guide).

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

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

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

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

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

3.1 Voluntary Termination of a County(ies)

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

- Submit three copies, with CPA's original signature, of current financial statements demonstrating fiscal soundness of the company's operations within the state of South Carolina
- Submit three copies, with a CPA's original signature, of current financial statements demonstrating the impact requested county(ies) would have on the overall fiscal soundness of the company's operations within the state of South Carolina should SCDHHS deny the request to restrict membership
- Copies of all executed subcontracts, including rates, from the requested counties; MCO understands, if SCDHHS agrees to the voluntarily termination, all healthcare provider contracts, for example but not limited to: Hospital, PCP, specialties, physicians, etc. will be terminated in accordance with SCDHHS' scheduled project plan
- Updated county network submissions reflecting the removal of the following providers from your South Carolina network:
 - a. Thirty (30) miles from the border of the requested counties for Primary Care Providers (*Primary Care includes those OB/GYN Providers who have agreed to serve as a Primary Care Provider for pregnant members*);

- b. A 50-mile radius from the border of the requested counties for Specialty and Ancillary Service Providers;
 - c. Hospitals:
 - i. Up to and including a 100-mile diameter from the border of the requested counties for Children and Level I Trauma Hospitals;
 - ii. Up to and including a 75-mile diameter from the border of the requested counties for urban or county hospitals servicing more than one county;
 - iii. Up to and including a 50-mile diameter from the border of the requested counties for rural county hospitals.
- Upon SCDHHS's approval to voluntarily terminate a county(ies), written confirmation of the termination of all provider subcontracts within the county(ies) involved

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

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

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

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

4.0 PROVIDER CERTIFICATION AND LICENSING

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

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

- All providers billing laboratory procedures must have a Clinical Laboratory Improvement Amendment (CLIA) Certificate. Only services consistent with their type of CLIA certification may be provided.
- Inpatient/Outpatient hospital Providers must be surveyed and licensed by the Department of Health and Environmental Control (DHEC), certified by CMS, or accredited by a national accreditation organization contracted with CMS, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or Det Norske Veritas (DNV). Accredited providers only require licensing by the DHEC.
- Ambulatory surgical centers must be surveyed and licensed by DHEC, certified by the CMS, and accredited by a nationally recognized body.
- End stage renal disease clinics must be surveyed and licensed by DHEC, and certified by the CMS.
- Laboratory testing facilities providing services must have a CLIA Certificate of Waiver, or a Certificate of Registration with a CLIA identification number per federal regulations. Laboratories can only provide services consistent with their type of CLIA certification.
- Infusion Centers have no licensing or certification requirements.
- Medical professionals to include, but not limited to physicians, physician's assistants, certified nurse midwives/ licensed midwives, certified registered nurse anesthetists (CRNAs)/ anesthesiologist assistants (AAs), nurse practitioners/ clinical nurse specialists, podiatrists, chiropractors, private therapists and

audiologists must all be licensed and certified to practice by the appropriate Board/ Licensing body (i.e. Board of Medical Examiners, Board of Nursing, Council on Certification of Nurse Anesthetists, Board of Podiatry Examiners, Board of Chiropractic Examiners, Board of Occupational Therapy, Board of Physical Therapy, Board of Examiners in Speech Language Pathology and Audiology).

- Federally Qualified Health Clinics (FQHCs) must have a Notice of Grant Award under 319, 330 or 340 of the Public Health Services Act and be certified by CMS. FQHCs billing laboratory procedures must have a CLIA certificate.
- Rural Health Clinics (RHCs) must be surveyed and licensed by DHEC and certified by CMS. RHCs billing laboratory procedures must have a CLIA Certificate. Laboratories can only provide services that are consistent with their type of CLIA certification.
- Alcohol and Substance Abuse clinics are required to be licensed by DHEC.
- Mental health Clinics (DMH) must be a Department of Mental Health (DMH) sanctioned Community Mental Health Center. Out-of-state Providers must furnish proof of Medicaid participation in the State in which they are located.
- Portable x-ray Providers must be surveyed by DHEC and certified by CMS.
- Stationary x-ray equipment must be registered with DHEC.
- Mobile ultrasounds require no license or certification.
- Physiology lab Providers must be enrolled with Medicare.
- Mammography service facilities providing screening and diagnostic mammography services must be certified by the USDHHS, Public Health Services, Food and Drug Administration (FDA).
- Pharmacy Providers must have a permit issued by the Board of Pharmacy under the South Carolina Department of Labor, Licensing and Regulations.
- 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.

4.1 Initial Credentialing and Recredentialing Policy

The MCO will develop and maintain written credentialing Policies and procedures regarding the initial credentialing and recredentialing processes of all physicians. Any changes to the MCOs credentialing or recredentialing Policies and procedures must be submitted to SCDHHS for approval prior to implementing the changes. The changes must be submitted to SCDHHS prior to implementation and follow the same submission process as changes outlined in the contract submission process.

An initial onsite review is required of all Primary Care Physicians and high volume OB/GYN Physicians, as defined in this Guide, prior to the completion of the initial credentialing process. The MCO must assess the Quality, safety, and accessibility of all office sites (including part-time or satellite offices) where care is delivered. MCO staff conducting the on-site review must be trained and qualified to perform the review(s). The MCO is required to send SCDHHS training policies and personnel qualifications for staff conducting on-site reviews.

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

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

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

4.2 MCO Credentialing Committee and the Credentialing Process

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

Credentialing must be completed and approved by the MCO Credentialing Committee for all Medicaid provider(s) who participate with the MCO prior to serving Medicaid MCO members. If an MCO Provider has been credentialed using the MCO's commercial credentialing process, the MCO Medical Director must sign an attestation stating the commercial credentialing meets SCDHHS Medicaid MCO credentialing criteria.

For existing Medicaid-only Providers, MCOs must conduct the recredentialing process in accordance with SCDHHS criteria. For Providers who serve both the commercial and Medicaid populations, the credentialing committee must acknowledge in separate minutes the Provider(s) have met SCDHHS criteria. These minutes must be attached to the Provider(s) Medicaid credentialing file. An identifiable separate page and/or section (also included in the file) of the minutes that addresses Medicaid Providers is also acceptable.

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

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

- o Attestation: Correctness and completeness of application

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

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

MCOs are held accountable for ensuring delegated entities follow the requirements as set forth in the MCO's Policies which are based on the guidelines as outlined in SCDHHS' Policy and Procedure Guide. For delegated Primary Care and high volume OB/GYNs, MCOs must conduct an initial on-site review. MCOs must also perform an on-site audit of all delegated entity's Policies and procedures to ensure compliance with the MCO's existing Policies. This review must include, at a minimum, a sample detailed analysis of 12% of the files (6% must be (new) initial credential files and 6% of recredentialing files). If there are no initial credentialing files to verify then 6% of the recredentialing files must be reviewed. The MCO must repeat this process annually. Recredentialing for delegated entities will be completed no less than every three years.

The MCO may not allow the delegated entity to Subcontract any portion of their credentialing activities without prior approval by SCDHHS. In support of SCDHHS approval, the subdelegated entity must be credentialed by a nationally recognized quality organization as confirmed by SCDHHS. Copies of the national organization's accreditation must be provided to SCDHHS.

The above guidelines apply to all services to include Core and Additional Services as offered by the MCO.

Whether the MCO does the initial credentialing/recredentialing, or it has delegated this function to another approved delegated entity, the MCO is responsible to have an ongoing monitoring program of the Provider(s) who participate(s) in Medicaid through a contract with the MCO. The monitoring program must have Policies and procedures in place to monitor Provider(s) sanctions, complaints, and quality issues between recredentialing cycles, and must take the appropriate action against Providers when it identifies any of the above listed occurrences.

The MCO may use its own credentialing application until such time as the SCDHHS has designated an approved format.

5.0 BENEFICIARY ENROLLMENT

5.1 Who is Eligible to Enter an MCO?

This program is limited to certain Medicaid Eligibles who:

- Do not also have Medicare
- Are under the age of 65
- Are not in a nursing home
- Do not have limited benefits such as Family Planning, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Are not participating in a Home or Community Based Waiver program
- Are not participating in Hospice
- Are not participating in the PACE program
- Do not have an MCO through third party coverage
- Are not enrolled in another Medicaid managed care plan

5.2 Managed Care Enrollment Process

SCDHHS has instituted an Enrollment process for Medicaid managed care called South Carolina Healthy Connections Choices (SCHCC). It is currently operated under contract with MAXIMUS Inc. Additional details on SCHCC may be found at www.scchoices.com. Newly eligible Medicaid beneficiaries and beneficiaries going through the yearly eligibility re-determination process who also meet the criteria for Medicaid managed care participation will be informed of their various managed care choices. Before being assigned to a plan by SCHCC, Beneficiaries who are eligible for plan assignment are given at least thirty (30) days to choose a MCO/MHN. Beneficiaries not eligible for plan assignment may proactively enroll in a Managed Care Plan.

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

5.3 Managed Care Enrollment of Newborns

All Newborns of Medicaid MCO Members, where the Newborn resides in the same household as the mother, are the responsibility of the MCO. A Newborn is defined as a Medicaid-Eligible Beneficiary who is under 365 days of age.

To assure Continuity of Care in the crucial first months of the Newborn's life, every effort shall be made by SCDHHS to expedite Enrollment of a Newborn into the MCO's Plan.

SCDHHS eligibility staff will attempt to link all Newborns to a Medicaid mother when appropriate information is available. In the absence of a linkage between the Newborn and mother in the SCDHHS MEDS system, the Newborn will be considered non-linked.

For the first year of life, non-linked Newborns will:

1. Remain in fee-for-service Medicaid, or
2. Be enrolled into a health plan by the person responsible for the Newborn.

If the Newborn remains in FFS Medicaid after their first birthday, the Enrollment rules that apply to the remainder of the population will be applied to this Beneficiary.

Linked Newborns that become Medicaid Eligible within the first three (3) months of life (as determined by the monthly cutoff date) will be enrolled as follows:

- If mother was enrolled in an MCO health plan in the birth month, the Newborn will be retroactively assigned to that health plan. The Newborn will remain in that health plan for the remainder of the year unless the mother changed MCO plans during the second or third month of the Newborn's life. In those cases, the Newborn will be transferred to the next MCO health plan for the remainder of their first year in managed care. If the mother transfers out of an MCO health plan (to an MHN or to fee-for-service Medicaid), the Newborn will not be transferred from the MCO's Plan.
- If mother was enrolled in an MHN health plan in the birth month, the newborn will NOT be assigned to that plan. If the mother had transferred to an MCO health plan in month's two or three of the newborn's life, the newborn will be assigned to that plan for the remainder of their first year in managed care.
- If the mother was not enrolled in any health plan during the first three months of the Newborn's life, the Newborn will receive an outreach Enrollment packet and the mother will have the option of selecting a health plan for the Newborn. This selection will begin on the first day of the next available assignment period after the choice is made.

Linked Newborns that become Medicaid Eligible after the first three (3) months of life will not be considered for retroactive Enrollment to the birth month. These members will be considered for Enrollment in the next available assignment period. The available

health plan will be determined by the health plan that the mother is in for that upcoming assignment period.

- If mother is, or will be, enrolled in an MCO health plan for the upcoming assignment period, the Newborn will be auto-assigned to that plan.
- If mother will not be enrolled in any health plan for the upcoming assignment period, the Newborn will receive an Outreach Enrollment packet and the mother will have the option of selecting a health plan for the Newborn. This selection will begin on the first day of the next available assignment period after the choice is made.

Atypical cases, whether identified by the Enrollment counselor (MAXIMUS, Inc.), the SCDHHS or an MCO, will be researched and resolved by SCDHHS. A change made to the mother's Medicaid ID is one example of an atypical case.

MCOs receive a Daily Newborn Enrollee file, which must be processed daily. Using the Newborn Enrollment Error form, MCOs must report any errors in Newborn Enrollment to SCDHHS within seventy-two (72) business hours of identification. SCDHHS will review the Newborn's record in an effort to validate the error. If the error can be validated and the Newborn is within the first three (3) months of life, SCDHHS will correct the Enrollment error within seventy-two (72) business hours of the notification. If the Enrollment correction is dependent on a change being made to the Newborn's eligibility record, SCDHHS staff cannot make the correction until the eligibility record has been updated.

5.4 Managed Care Enrollment Period

Medicaid MCO Members shall be enrolled for a period of twelve (12) months contingent upon their continued Medicaid eligibility. The Medicaid MCO Member may request Disenrollment once without cause at any time during the ninety (90) days following the date of the member's initial Enrollment or re-Enrollment with the MCO. After the end of this ninety (90) day period, a Medicaid MCO Member shall remain in the MCO's plan unless the Medicaid MCO Member:

- Submits an electronic, oral or written request to disenroll or change Managed Care Plans for cause which is subsequently approved by SCDHHS
- Becomes ineligible for Medicaid, and/or
- Becomes ineligible for MCO Enrollment

A Medicaid MCO Member may request Disenrollment from the MCO as follows:

- For cause, at any time
- Without cause, at the following times:

- o During the ninety (90) days following the Medicaid MCO Members initial Enrollment or re-Enrollment with the MCO
- o At least once every twelve (12) months thereafter

All Medicaid MCO Member initiated Disenrollment requests must be made to South Carolina Healthy Connections Choices (SCHCC), the SCDHHS's Enrollment Broker.

A Medicaid MCO Member's request to disenroll must be acted on no later than the first day of the second month following the month in which the Medicaid MCO Member filed the request. If not, the request is automatically approved.

A Medicaid MCO Member may request Disenrollment from the MCO for cause at any time. For cause Disenrollment requests must be submitted to SCHCC on the appropriate SCHCC form.

The following are considered cause for Disenrollment by the member:

- The Medicaid MCO Member moves out of the MCO's Service Area
- The plan does not, because of moral or religious objections, cover the service the Medicaid MCO Member seeks
- The Medicaid MCO Member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network; and the Medicaid MCO Member's PCP or another Provider determines that receiving the services separately would subject the enrollee to unnecessary risk
- Other reasons, including but not limited to, poor Quality of care, lack of access to services covered under the contract, or lack of access to Providers experienced in dealing with the member's healthcare needs

Prior to approving the Medicaid MCO Member's Disenrollment request, SCDHHS will refer the request to the MCO to explore the Medicaid MCO Member's concerns and attempt to resolve them. The MCO will notify SCDHHS within ten (10) calendar days of the result of their intervention. The final decision on whether to allow the Medicaid MCO Member's Disenrollment rests with SCDHHS, not the MCO. If a decision has not been reached within sixty (60) days, the Medicaid MCO Member's request to disenroll is automatically approved. The Beneficiary will be disenrolled from the current plan effective the last day of the month and enrolled in the new plan effective the first of the following month. A key factor that determines the month of Disenrollment is the date the request is received vis-à-vis the monthly cut-off date. The cutoff for all actions is generally around 10 days prior to the end of the month (and varies each month). For example, if cut-off is August 20th and the request is received on August 19th, the effective date of Disenrollment will be October 1. If the request is received August 21st, the effective date of Disenrollment will be November 1.

Annually, SCDHHS will mail a re-Enrollment offer to Medicaid MCO Members to determine if they wish to continue to be enrolled with the MCO's plan. Unless the Medicaid MCO Member becomes ineligible for the Medicaid MCO Program or provides electronic, oral or written notification that they no longer wish to be enrolled in the MCO's plan, the Medicaid MCO Member will remain enrolled with the MCO.

5.5 Managed Care Disenrollment

Disenrollments may be initiated by (1) the Medicaid MCO Member, (2) SCDHHS, or (3) the MCO. Member-initiated Disenrollment is addressed above in the section entitled **Managed Care Enrollment Period.**

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

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

- Loss of Medicaid Eligibility or loss of Medicaid MCO program Eligibility
- Death of a member
- Member's intentional submission of fraudulent information
- Member becomes an Inmate of a Public Institution (See Appendix A – Definition of Terms.)
- Member moves out of state
- Member elects Hospice
- Member becomes Medicare Eligible
- Member becomes institutionalized in a Long-Term Care facility or nursing home for more than ninety (90) continuous days
- Member elects home and community based waiver programs
- Loss of Medicaid MCO participation
- Member becomes age 65 or older
- Enrollment in a commercial HMO

- Member is placed out of home [*i.e.*, Intermediate Care Facility for the Mentally Retarded (ICF/MR), Psychiatric Residential Treatment Facility (PRTF)]
- Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the MCO's ability to furnish services to the member or other enrolled members

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

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

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

The MCO's request for Medicaid MCO Member Disenrollment must be made in writing to South Carolina Healthy Connections Choices (SCHCC). The request must state, in detail, the reason for Disenrollment. SCHCC will log this request and forward it to SCDHHS for review. SCDHHS will determine if the MCO has shown good cause to disenroll the Medicaid MCO Member and SCDHHS will give written notification to the MCO and the Medicaid MCO Member of its decision. During this process, SCDHHS may request the MCO to provide additional information and documentation. The MCO and the Medicaid MCO Member shall have the right to appeal any adverse decision.

The MCO may not request Disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued Enrollment in the Plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees).

The same time frames that apply to Enrollment shall be used for changes in Enrollment and Disenrollment. If a Medicaid MCO Member's request to be disenrolled or change MCO plans is received and processed by SCDHHS by the internal cut-off date for the month, the change will be effective on the last day of the month. If the Medicaid MCO Member's request is received after the internal cut-off date, the effective date of the change will be no later than the last day of the month following the month the Disenrollment form is received. A Medicaid MCO Member's Disenrollment is contingent upon their "lock-in" status (See the **Managed Care Enrollment Period** section).

5.6 Payment Responsibility for Hospital Stays When Enrollment/Disenrollment Occurs

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. The date of service will dictate the responsible MCO for physician charges. Similarly, if the Medicaid MCO Member is FFS on the date of admission, FFS Medicaid is responsible for facility charges for the duration of the stay to discharge and the MCO is responsible for physician charges based on the date of service.

For example, an MCO (MCO1) member is admitted to a hospital on August 20th and discharged on September 15th. On September 1, the member changed to a new MCO (MCO2). MCO1 is responsible for the 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 responsible for all physician charges from September 1st to September 15th.

6.0 PAYMENTS and ADJUSTMENTS

The MCO will be paid through a Capitated Payment to provide services to Medicaid MCO Members. The monthly Capitated Payment is equal to the monthly number of Medicaid MCO Members in each Medicaid MCO Member category multiplied by the established rate for each group.

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

Some payments, however, may be paid to the MCO through an adjustment. If the adjustment processed by the SCDHHS Department 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 their SCDHHS program manager for each of these adjustments. It is the MCO's responsibility to reconcile the "gross-level" adjustments sent to the MCO.

The following payments will be paid through gross-level adjustments, rather than through capitation.

6.1 Retrospective Review and Recoupment – Dual Eligible

Beneficiaries who are dually Eligible (Medicare and Medicaid) are not Eligible to be in an MCO; however, individuals enrolled in an MCO may receive Medicare eligibility retroactively. Upon notification of Medicare Enrollment, MCOs may recoup provider payments for the time period from the effective date of retroactive Medicare eligibility to the present, not to exceed twelve (12) months.

6.2 Retrospective Review and Recoupment – Non-Dual Eligible

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

6.3 Rate Change Adjustments

In the event CMS approves a rate change and authorizes the new rate be implemented retroactively, the SCDHHS financial staff will calculate any appropriate credit/debit adjustments due to/from the MCO. If there are material changes, as determined by SCDHHS, to the Medicare fee schedule and subsequent changes to the Medicaid fee schedule during the Contract period, SCDHHS reserves the right to adjust the capitation rates accordingly.

6.4 Sanctions

The preferred method for enforcing monetary sanctions imposed by SCDHHS is via the debit adjustment process. Reasons for sanctions are defined in the Sanction section of the Contract.

6.5 Capitation / Premium Payment Adjustment

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

6.6 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.

6.7 FQHC / RHC Wrap Payment Process

Background Information

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 require the determination of supplemental payments for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) contracting with Medicaid Managed Care Organizations (MCOs). These supplemental payments are calculated and paid to ensure these Providers receive reimbursement for services rendered to Medicaid MCO Members at least equal to the payment that would have been received under the traditional fee for service methodology. These determinations, generally referred to as Wrap-Around payments, are mandated by BIPA 2000 to be completed at least every four (4) months. SCDHHS is the state agency responsible for the Wrap-Around payment methodology. This reconciliation is incorporated into the agency's State Plan for Medical Assistance.

Specific requirements for FQHCs and RHCs contracting with Medicaid MCOs are contained in the MCO contract. The Medicaid MCO shall submit on a quarterly basis, by date of service, a report of all paid and denied Encounter/claim data for all contracting FQHCs and RHCs for State Plan required reconciliation purposes. This Encounter/claims data will be submitted no later than sixty (60) days following the quarter's end date. For information on the reporting structure or format, please see the MCO Reports Guide on the SCDHHS Web site – www.scdhhs.gov.

7.0 Grievance (Complaint)

A member grievance (complaint) is an expression of dissatisfaction by a Medicaid MCO Member to the MCO. Examples of dissatisfaction include, but are not limited to, situations where a provider was rude, poor lighting in the provider's waiting room, lack of seating, or an unclean bathroom in the provider's office., The MCO is required to investigate these types of grievances (complaints) and respond to the Medicaid MCO Member within five (5) business days. An adverse final resolution regarding the member's grievance does not provide the member with the right to a state fair hearing.

8.0 Appeals and State Fair Hearings

The relationship between the MCO and the provider is governed entirely by the contract between the parties. In this contract the provider agrees to accept Medicaid Members and the MCO agrees to pay for the provision of services as outlined in the contract. Thus, the issue of payment to the provider by the MCO is an issue between the two parties. SCDHHS is not a party to this agreement and will not exercise its authority to enforce the provisions of the contract between the MCO and the provider.

SCDHHS' responsibility is to ensure members receive the services required by the contract between SCDHHS and the MCO. SCDHHS expects the MCO will enforce its contracts with providers to render these services.

Providers should follow the MCO's appeals process as outlined in their contract and the MCO's Provider handbook should they dispute the MCO's payment, and/or Utilization Management/ Utilization Review decision. A Member's signature is not required for a Provider to appeal as outlined above.

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

Pursuant to the CFR, the Provider does not have a due process right to a state fair hearing. The member drives the process because this appeals and state fair hearing process is for the benefit of the member.

9.0 Prior Authorization (PA) – Decision Time Frames and Special Instructions

Prior Authorization (PA) is defined as the act of authorizing specific approved services by the MCO before they are rendered. In accordance with 42 CFR §438.210, Plan responses to requests for Prior Authorizations shall not exceed the following time frames:

Standard Authorization Decisions – For standard authorization decisions, provide notice as expeditiously as the enrollee's health condition requires and within State-established time frames that may not exceed fourteen (14) calendar days following receipt of the request for service.

Expedited Authorization Decisions – For cases in which a Provider indicates, or the Plan determines, following the standard time frame could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function, the Plan must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than three (3) business days after receipt of the request for service.

Any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested must be made by a healthcare professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

As stated in the MCO contract, when a Medicaid MCO Member entering an MCO is receiving medical services the day before Enrollment, whether such services were provided by another MCO or Medicaid fee-for-service, the MCO is responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contracted or Non-Contracted Providers. That MCO shall provide continuation of such services until the member is released by the current provider and can be transferred without disruption or finishes the course of treatment.

In addition, for Medicaid MCO Members with the following pharmacy drugs , the MCO must provide continuation of pharmaceutical services and/or accept a Prior Authorization from SCDHHS or another health plan for an additional thirty (30) days for a total of up to sixty (60) calendar days or until the Medicaid MCO Member may be transferred without disruption, whichever is less: major depression, schizophrenia, bipolar disorder, major anxiety disorder, and attention-deficit or hyperactivity disorder.

Universal PA Medications Form, - Effective October 1, 2012 all MCOs shall accept the Universal Prior Authorization form for medications. The form was developed and implemented as a means of facilitating the PA process across all MCOs and is located on the SCDHHS Website under Reference Tools in the Managed Care section

Universal Newborn PA Process – A Universal Newborn Prior Authorization form has been developed and implemented as a means of facilitating the PA process for services rendered in an office setting within sixty (60) days following hospital discharge. This form is located on the SCDHHS Web site under Reference Tools in the Managed Care section. MCOs shall fully support this process in the interest of Continuity of Care and member satisfaction.

17-P 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 for all Medicaid MCO members beginning August 1, 2011, The 17-P form is located on the SCDHHS Web Site under Reference Tools in the Managed Care section.

9.1 Medicaid MCO Member Billing

Provider may only bill a Medicaid MCO Member under the following conditions:

1. When Provider renders services that are Non-Covered Services and are not Additional Services offered by the MCO, as long as Provider:
 - a. Provides to the Medicaid MCO Member a written statement of the services prior to rendering said services, which must include:
 - i. The cost of each service(s)
 - ii. An acknowledgement of Medicaid MCO Member's payment responsibility
 - iii. Obtains Medicaid MCO Member's signature on the statement
2. When the service provided has a copayment as allowed by the MCO, Provider may charge Medicaid MCO Member only the amount of the allowed copayment, which cannot exceed the copayment amount allowed by SCDHHS.

10.0 CORE BENEFITS

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

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

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

MCO plans may offer Additional Services to Medicaid MCO Members. Changes or deletions to the Additional Services made during the contract year must be submitted to SCDHHS for approval. These Additional Services may include medical services which are currently non-covered and/or which are above current Medicaid limitations. If the MCO elects not to provide, reimburse for, or provide coverage of a service because of an objection on moral or religious grounds, the MCO must furnish information about the services it does not cover as follows:

- To the State with its application for a Medicaid contract, or whenever it adopts the policy during the term of the contract
- The information must be provided to potential enrollees before and during enrollment
- The information must be provided to enrollees within ninety (90) days after adopting the policy

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

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

10.1 Ambulance Transportation

All transportation services provided via ambulance (provider type 82) are the responsibility of the MCO. These trips may be routine or non-routine transports to a Medicaid covered service. The MCO will provide stretcher trips, as well as, air ambulance or Medivac transportation.

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. MCOs may require the same level of documentation from the Provider as required by the fee-for-services system.

Transportation for Out-of-State Medical Services

Medicaid MCO Members are eligible for Prior Authorized transportation as described below:

- If the MCO authorizes out-of-state referral services and the referral service is available in-state, the MCO is responsible for all Medicaid covered services

related to the referral to include all modes of transportation, escorts, meals, and lodging.

- If the MCO authorizes out-of-state services and the service is not available in-state, the MCO will be responsible for the cost of referral services and any ambulance or Medivac transportation.

Back Transfers

The MCO is expected to coordinate the transfer of Members from one hospital to another hospital, or from a hospital to a lower level of care, when requested by the Provider. The MCO must consider and cannot deny a transfer for social reasons (e.g., so a Member can be closer to a family support system, etc.) provided the medical records justify the need for the transfer and the Member still requires acute hospital care.

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.

10.2 Ancillary Medical Services

Ancillary medical services, including, but not limited to pathology, radiology, emergency medicine and anesthesiology are part of the managed care rate and covered under hospital inpatient. When the Medicaid MCO Member is provided these services the MCO shall reimburse the professional component of these services at the Medicaid fee-for-service rate, unless another reimbursement rate has been previously negotiated. Prior Authorization for these services shall not be required of either network or non-participating providers. All anesthesia services, even those associated with behavioral health and dental procedures, are the responsibility of the MCO.

10.3 Audiological Services

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

The MCO is responsible for providing a range of examinations, fittings and related audiological services. The specific procedures and limitations are listed in the Private Rehabilitative Therapy and Audiological Services Provider Manual and updated via Medicaid bulletins. Pricing is available from the monthly fee schedule and/or contract schedule provided to MCOs.

10.4 Chiropractic Services

Chiropractic services are available to all beneficiaries. Chiropractic services are limited to manual manipulation of the spine to correct a subluxation. Chiropractic visits are counted separately from the ambulatory visit limit.

10.5 Communicable Disease Services

An array of communicable disease services is available to help control and prevent diseases such as TB, syphilis, and other sexually transmitted diseases (STD's) and HIV/AIDS. Communicable disease services include examinations, assessments, diagnostic procedures, health education and counseling, treatment, and contact tracing, according to the Centers for Disease Control (CDC) standards. In addition, specialized outreach services are provided such as Directly Observed Therapy (DOT) for TB cases. Eligible Recipients should be encouraged to receive TB, STD, and HIV/AIDS services through their Primary Care Provider or by appropriate referral to promote the integration/coordination of these services with their total medical care. Eligible Recipients have the freedom to receive TB, STD and HIV/AIDS testing and counseling services from any public health agency without any restrictions to services.

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

10.6 Disease Management

Disease Management is comprised of all activities performed on behalf of Medicaid MCO Members with special healthcare needs to coordinate and monitor their treatment for specific identified chronic/complex conditions and diseases, and to educate Medicaid MCO Members to maximize appropriate self-management.

10.7 Durable Medical Equipment

Durable medical equipment is equipment that provides therapeutic benefits or enables a Beneficiary to perform certain tasks he or she would otherwise be unable to undertake due to certain medical conditions and/or illnesses. Durable medical equipment is equipment that can withstand repeated use and is primarily and customarily used for medical reasons, and is appropriate and suitable for use in the home. This includes

medical products; surgical supplies; and equipment such as wheelchairs, traction equipment, walkers, canes, crutches, ventilators, prosthetic and orthotic devices, oxygen, hearing aide 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 attending physician has the responsibility of determining the type or model of equipment needed and length of time the equipment is needed through a written necessity statement. 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. Repairs to medical equipment are covered if reasonable.

Should a Medicaid MCO Member change plans, the new MCO is required to honor existing Prior Authorizations for Durable Medical Equipment for a period of no less than thirty (30) days.

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

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

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

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

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

10.9 Family Planning

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

Eligible Beneficiaries should be encouraged to receive Family Planning Services through an in network Provider or by appropriate referral to promote the integration/coordination of these services with their total medical care. However, Eligible Beneficiaries have the freedom to receive Family Planning Services from any appropriate Medicaid Providers without any restrictions. If the Medicaid MCO Member receives these services through the MCO Primary Care Provider, the MCO is responsible for reimbursement for the services. If the Medicaid MCO Member receives these services outside the MCO network, Providers will be reimbursed through the Fee-for-Service system. If an MCO has been approved to operate under the section of the MCO SCDHHS contract titled “Moral or Religious Objections to Providing Certain Covered Services,” the Fee-for-Service system is responsible for payment Medicaid MCO Member who receives the services through their Primary Care Provider or outside of the MCO network. For a list of Family Planning codes, please see Section 4 of the [Physicians, Laboratories, and Other Medical Professionals Provider Manual](#) on the SCDHHS website.

10.10 Hearing Aids and Hearing Aid Accessories

The MCO is responsible for providing hearing aids and accessories to MCO Medicaid Members under age 21. The specific products and limitations are listed in the DME Provider manual and updated via Medicaid bulletin. Pricing is available from the monthly fee schedule and/or contract schedule provided to MCOs.

10.11 Home Health Services

Home Health services are healthcare services delivered in a person’s place of residence, excluding nursing homes and institutions, and include intermittent skilled nursing, home health aide, physical, occupational and speech therapy services, and physician ordered supplies.

10.12 Hysterectomies, Sterilizations, and Abortions

The MCO shall cover sterilizations, abortions, and hysterectomies pursuant to applicable Federal and State laws and regulations. When coverage requires the completion of a specific form, the form must be properly completed as described in the instructions with the original form maintained in the Medicaid MCO Member's medical file and a copy submitted to the MCO for retention in the event of audit. In the event a physician does not complete and submit the required specific forms referenced above, it is permissible for the MCO to delay or reject payment until such time as the forms are properly completed and submitted. It is **not** permissible for the MCO to deny or delay payment to the hospital or other ancillary Providers should the physician not complete or submit the required forms. Each claim must stand on its own merit, not upon a physician's failure to submit the required documentation.

The following are applicable current policies:

****Sterilizations and Abortions are not part of the Core Benefits offered under the Ethical Limitations section of the MCO contract.***

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

1. The individual or her representative, if any, must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing.
2. The individual or her representative, if any, must sign and date an acknowledgment of receipt of hysterectomy information form (see Forms section) prior to the hysterectomy. Informed consent must be obtained regardless of diagnosis or age.
3. The hysterectomy acknowledgment form is acceptable when signed after the surgery only if it clearly states that the patient was informed prior to the surgery that she would be rendered incapable of reproduction.
4. The acknowledgment form is not required if the individual was already sterile before the hysterectomy or if 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. Hysterectomy shall not be covered if performed solely for the purpose of rendering an individual permanently incapable of reproducing.
6. Hysterectomy shall not be covered if there was more than one purpose for performing the hysterectomy, but the primary purpose was to render the individual permanently incapable of reproducing.

Sterilizations*

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

1. Sterilization shall mean any medical procedure, treatment or operation done for the purpose of rendering an individual permanently incapable of reproducing.
2. The individual to be sterilized shall give informed consent not less than thirty (30) full calendar days (or not less than seventy-two (72) hours in the case of premature delivery or emergency abdominal surgery) but not more than one hundred eighty (180) calendar days before the date of the sterilization. A new consent form is required if 180 days have passed before the surgery is provided.

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

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

Abortions*:

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

The following guidelines are to be used in reporting abortions.

1. Diagnosis codes in the 635 range should be used ONLY to report therapeutic abortions.

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

Information regarding the appropriate CPT, ICD-9, and diagnosis codes for therapeutic abortions can be found in the Hospital Services Provider Manual. Please consult the monthly fee schedule for accurate payment information.

***Sterilizations, and Abortions, are not part of the Core Benefits offered under for the MCO that has been approved to operate under the Ethical Limitations section of the MCO contract. Members of an MCO operating under this section can remain with that MCO and obtain this service under the fee-for-service system.**

10.13 Independent Laboratory and X-Ray Services

Benefits cover laboratory and x-ray services ordered by a physician and provided by independent laboratories and portable x-ray facilities. An independent laboratory and x-ray facility is defined as a facility licensed by the appropriate State authority and not part of a hospital, clinic, or physician's office. In cases where the Department of Alcohol & Other Drug Abuse Services or the Department of Mental Health submit laboratory claims under Provider Type "80" (Independent Lab), MCOs are responsible for reimbursement. When these two agencies submit laboratory claims under Provider Type "10" (Mental Health/Rehabilitation), the claims are the responsibility of the Fee-for-Service reimbursement system.

10.14 Inpatient Hospital Services

Inpatient hospital services are those services, provided under the direction of a physician, furnished to a patient who is admitted to a general acute care medical facility on for a period greater than 24 hours. An admission occurs when the Severity of Illness/Intensity of Services criteria set forth by the review MCO and approved by SCDHHS is met. Among other services, inpatient hospital services encompass a full range of necessary diagnostic, therapeutic care including surgical, medical, general nursing, radiological and rehabilitative services in emergency or non-emergency conditions. Additional inpatient hospital services would include room and board, miscellaneous hospital services, medical supplies, and equipment. For information regarding payment responsibility when membership crosses two MCOs or MCO/FFS during a hospital stay, please see the section titled "**Payment Responsibility for Hospital Stays When Enrollment/Disenrollment Occurs**" located in the Beneficiary Enrollment section of this Guide.

Current Medicaid Service Limitations: Coverage of inpatient hospital services is limited to general acute care hospital services to include psychiatric services (DRGs 424-433, 521-523). Inpatient rehabilitative services provided in a separate medical rehabilitation facility or a separately licensed specialty hospital are not reimbursable. Rehabilitation services which are rendered to Medicaid Beneficiary on an inpatient or outpatient basis at a general acute care hospital are reimbursable.

10.15 Institutional Long-Term Care Facilities / Nursing Homes

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

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

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

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

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

- Review the completed assessment and follow policy for assessment
- Follow policy for level of care determination

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

10.16 Maternity Services

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

Hospital claims with both a cesarean section and sterilization are not reimbursed through Family Planning funding sources. Therefore, all MCOs are responsible for these inpatient hospital claims. MCOs that have been approved to operate under the section of the SCDHSMCO contract titled "Moral or Religious Objections to Providing Certain Covered Services" are not responsible for any associated sterilization professional fees. This will be reimbursed by the fee-for-service system.

10.17 Newborn Hearing Screenings

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

10.18 Outpatient Pediatric Aids Clinic Services (OPAC)

An Outpatient Pediatric AIDS Clinic (OPAC) is a distinct entity that operates exclusively for the purpose of providing specialty care, consultation and counseling services for Human Immunodeficiency Virus (HIV) infected and exposed Medicaid-eligible children and their families. Children who are born to HIV positive mothers, but do not test positive, are seen every three months in the clinic until they are two (2) years old. Those children that do test positive are seen twice a week for eight (8) weeks and then once a month until they are two (2) years old. Children who do not improve stay in the OPAC Program.

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

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

10.19 Outpatient Services

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

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

Services performed in an outpatient hospital setting are considered to be Family Planning services only when the primary diagnosis is “Family Planning.”

10.20 Physician Services

Physician services include the full range of preventive care services, Primary Care medical services and physician specialty services. All Services must be Medically Necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care and treatment of the specific condition. Physician services are performed at physician’s offices, patients’ homes, clinics, skilled nursing facilities. Technical services performed in a physician’s office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service.

10.21 Prescription Drugs

Prescription drug coverage will be provided by the MCOs according to the Medicaid MCO Member’s needs. Should a Medicaid MCO Member change plans, the new MCO is required to honor existing prescriptions needing a Prior Authorization under the new plan’s formulary for a period of no less than thirty (30) days. In addition, the MCO must provide continuation of pharmaceutical services and/or honor the Prior Authorization an additional thirty (30) days, for a total of up to sixty (60) days, or until the Medicaid MCO Member may be transferred without disruption when the Medicaid MCO Member has one of the following conditions:

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

MCOs are required to support the Universal PA Medication form implemented October 1, 2012 (see *the Prior Authorization section of this P&P Guide*) and to have a Pharmacy Override Policy which allows provision of no less than a five (5) day emergency supply of all prescription drugs. Information on the override policy is located on the agency Web site at www.scdhhs.gov.

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 by South Carolina Medicaid. Information regarding coverage allowance for non-formulary products must be disseminated to Medicaid MCO Members and Providers.

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

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

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

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

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

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

10.23 Psychiatric Services

Psychiatric services to include assessment, treatment plan development and modification, and therapy services are the responsibility of the MCO effective April 1, 2012,

10.24 Rehabilitative Therapies for Children – Non-Hospital Based

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

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

The specific services and fee-for-service limitations can be found in the Private Rehabilitative Therapy and Audiological Services Provider Manual.

10.25 Transplant and Transplant-Related Services

Group I – Kidney and Corneal

Kidney: The MCO is responsible for all services prior to 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 Division of Physician Services before the services are performed. The Division of Physician Services will review all Medicaid referrals for organ transplants and issue an approval or a denial.

Corneal: MCO is responsible for this service.

Transportation arrangement for Group I transplants are coordinated through the Division of Medical Support Services. For information on the transportation program, call or write:

SCDHHS
Division of Medical Support Services
PO Box 8206
Columbia, SC 29202
(803) 898-2655

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

The MCO is responsible for all services prior to 72 hour preadmission, post-transplant services (upon discharge) and post-transplant pharmacy services.

All potential Group II transplants, cadaver or living donor, must be authorized by SCDHHS, Department of Physician Services 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 (72 hours preadmission), the event (hospital admission through discharge), and post-transplant services up to 90 days from the date of discharge.

For information concerning the referral for medical evaluation and transplant arrangements, please contact the following:

Transplant Coordinator
Department of Physician Services
(803) 898-2660

10.26 Vision Care Services

All vision services for Medicaid MCO Members under age 21, with the exception of corrective appliances (glasses and frames, contact lenses) and associated fees (fitting and dispensing fees) are the responsibility of the MCO unless the services provided are additional vision services as outlined in the MCO's Medicaid Member and Provider handbooks. MCOs are responsible for one (1) vision test during any twelve (12) month period, as well as the other vision services outlined in the SCDHHS Physicians, Laboratories, and Other Medical Professionals Provider Manual.

10.27 Alcohol and Other Drug Abuse Treatment Services Authorized or Provided by State Agencies (DAODAS Services)

Beginning with dates of service on or after February 1, 2013, alcohol and other drug abuse treatment services provided by the Department of Alcohol and Other Drug Abuse Services (DAODAS) and its subcontracted 33 county alcohol and drug abuse authorities are part of the MCO's core benefit package. Alcohol and other drug abuse services will be provided by the MCOs according to the Medicaid MCO Member's needs. Medicaid members will be assessed by one of the 33 county alcohol and drug abuse authorities and an Individual Plan of Care will be completed (IPOC).

All MCO members requiring level 1 (discrete) or level 2 (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, partial hospitalization and/or day treatment through DAODAS or its subcontracted authorities will require their rendering provider call the MCO to request a PA for both the initial and a continuation of services. Service level agreements are in place with the MCOs to ensure a timely response from provider requests for PA. MCOs have a maximum of five (5) business days to respond to initial PA requests for level 1 and level 2 services, and a maximum of fourteen (14) calendar days to respond to PA requests for a continuation of existing services for level 1 and level 2 services. MCOs are to respond to PA requests for detox, residential, partial hospitalization and/or day treatment within twenty-four (24) hours, or no later than close of the following business day. Should a member step down to level 1 or 2 services, the MCO is expected to provide a temporary PA to cover level 1 and/or 2 services for a period of five (5) days, permitting the rendering provider adequate time to fax documents as outlined above.

11.0 SERVICES OUTSIDE THE CORE BENEFITS

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

11.1 Mental Health

Mental health services authorized or provided by a state agency are reimbursed by Medicaid fee-for-service. Such services require a unique authorization number issued by the state agency to ensure the claim is appropriately adjudicated by SCDHHS.

The MCO shall coordinate the referral of Medicaid MCO Members for services that are outside of the required Core Benefits and which will continue to be provided by enrolled Medicaid Providers. These services are consistent with the outline and definition of Covered Services in the Title XIX SC State Medicaid Plan. These services include, but are not limited to, Targeted Case Management services, intensive family treatment services, therapeutic day services for children, out-of-home therapeutic placement services for children, inpatient psychiatric hospital and residential treatment facility services.

11.2 Medical (Non-Ambulance) Transportation

Medical non-ambulance transportation is defined as transportation of the Beneficiary to or from a Medicaid Covered Service to receive medically necessary care. This transportation is only available to Eligible Beneficiaries who cannot obtain transportation on their own through other available means, such as family, friends or community resources. The MCO should assist the Medicaid MCO Member in obtaining medical transportation services through the SCDHHS Enrollment broker system as part of its

Care Coordination responsibilities, as detailed below. See Appendix 3 for Enrollment broker contact information.

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

These are transports of Medicaid MCO Members to Covered Services as follows:

- Urgent transportation for Medicaid MCO Member 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 Members (Any planned and/or scheduled transportation needs for Medicaid Beneficiaries must be prearranged via direct contact with the regional brokers)
- Non-Emergency transports requiring BLS that are planned/scheduled transports to a scheduled medical appointment (*i.e.*, transport from nursing home to physician's office, nursing home to dialysis center or hospital to residence)
- Non-Emergency wheelchair transports that require use of a lift vehicle and do not require the assistance of medical personnel on board at the time of transport to medical appointments for Eligible Beneficiaries (These transports do not require the use of an ambulance vehicle.)

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

11.3 Vision Care Services

Medicaid MCO Members age 21 and older may only receive vision services when those services are identified as being Medically Necessary and not routine care. MCOs may offer additional vision benefits to Beneficiaries age 21 and over to include routine care. For details, see the MCO's Member and Provider Handbooks.

11.4 Dental Services

Routine and emergency dental services are available to Medicaid MCO Members under the age of 21. The dental program for Medicaid MCO Members under age 21 is administered by the SCDHHS dental broker, DentaQuest.

Dental services are a non-covered benefit for Medicaid MCO Members age 21 and over unless dental services are offered by the MCO in which the Medicaid MCO Member is enrolled. MCO covered dental services are outlined in the MCO's Member and Provider Handbooks.

Dental services for Medicaid MCO Members age 21 and over covered by SCDHHS on a fee-for-service basis are limited to dental procedures performed for the following medical reasons:

- Organ Transplants
- Oncology:
 - Radiation of the head and/or neck for cancer treatment
 - Chemotherapy for cancer treatment
- Total Joint Replacement
- Heart Valve Replacement

11.5 Targeted Case Management (TCM) Services

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

- Department of Mental Health: Services for chronically, mentally ill adults and children with serious emotional disturbances
- Department of Alcohol and Other Drug Abuse Services: Services for substance abusers and/or dependents
- Department of Juvenile Justice: Services for children ages 0 to 21 years receiving community services (non-institutional level) in association with the juvenile justice system
- Department of Social Services: a) Services to emotionally disturbed children ages 0 to 21 years in the custody of DSS and placed in foster care, and adults 18 years old and over in need of protective services and b) vulnerable adults in need of protective custody
- Continuum of Care for Emotionally Disturbed Children: Children ages 0 to 21 years who are severely and emotionally disturbed
- Department of Disabilities and Special Needs: Services to individuals with mental retardation, developmental disabilities, and head and spinal cord injuries.

(Additional services available under fee-for-service include Early Intervention Care Coordination and Family Training.)

- South Carolina School for the Deaf and the Blind: Services to persons with sensory impairments. [Additional services available under fee-for-service include Early Intervention Care Coordination and Family Training for children up to age six (6)]
- Sickle Cell Foundations and other authorized Providers: Services for children and adults with sickle cell disease and/or traits that enable Beneficiaries to have timely access to a full array of needed community services and programs that can best meet their needs
- The Medical University of South Carolina: Services to children and adults with sickle cell disease

11.6 Home- and Community-Based Waiver Services

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

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

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

- Women at or below 185% of federal poverty level for Family Planning Services only.

An array of Family Planning Services is available to help prevent unintended or unplanned pregnancies. Family Planning Services include examinations, assessments, diagnostic procedures, health education and counseling services related to alternative birth control and prevention as prescribed and rendered by physicians, hospitals, clinics, and pharmacies. Covered Services include traditional contraceptive drugs and supplies and preventive contraceptive

methods. Family Planning Services are also available through special pregnancy prevention programs.

11.7 Pregnancy Prevention Services – Targeted Populations

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

11.8 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. The MCO Primary Care Provider should contact the SCDHHS MAPPS Program Representative at (803) 898-2655 or approved service Providers (to set up a system of referral to this Program as needed).

11.9 Developmental Evaluation Services (DECs)

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

12.0 THIRD-PARTY LIABILITY

Third-Party Liability (TPL) is roughly analogous to coordination of benefits for health insurance. Medicaid, however, is secondary to all other insurance (and most but not all governmental health programs) so the savings of TPL are substantial.

Specific Areas for TPL Activity:

A. Comprehensive Insurance Verification Activities

SCDHHS has a contract in place for insurance verification services. Leads from the following sources are verified by the 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 Employment Security, TRICARE, and IRS
- Insurer leads
- Leads from claims processing

The TPL database is an integral part of Medicaid's claims processing system. Verification includes policy and Beneficiary effective dates, Covered Services, persons covered by the policy, maternity indicators, claim filing addresses and premium amounts. This data is updated continuously as new information is received. Only verified TPL coverage data will be passed to MCOs.

Experience has shown that employers are the best source for the majority of information concerning their group health plans. Additionally, SCDHHS and its Insurance Verification Services contractor have developed over 120 employer prototypes to aid in the loading of accurate, consistent data into the TPL database.

B. Cost Avoidance

Cost Avoidance refers to the practice of denying a claim based on knowledge of an existing health insurance policy which should cover the claim. The Medicaid allowed amount for a claim which is cost-avoided is stored in a "potential action" file. It is adjusted as necessary if insurance denies payment or if insurance doesn't pay the full Medicaid allowed amount and Medicaid reimburses the difference. The resulting system-calculated totals for cost avoidance represent true savings for the Medicaid program.

C. Aggressive Benefit Recovery Activities

SCDHHS utilizes a quarterly billing cycle to recover Medicaid expenditures for claims which should be covered by other third party resources. At the end of each quarter, the Medicaid claims database is searched automatically for claims which should have been covered by Policies added during the quarter and also for claims which were not cost avoided. Automated letters are generated to Providers and insurance carriers requesting reimbursement of Medicaid payments. Follow-up letters are automatically generated if refunds have not been made within a set period of time. Provider accounts may be debited if refunds are not made. Denials of payment by insurance companies may be challenged for validity and/or accuracy. Every attempt is made to satisfy plan requirements so that carriers will reimburse Medicaid.

The following types of recoveries are initiated by SCDHHS:

1. Health Insurance Recoveries – Such recovery is done on a quarterly basis for both "pay and chase" and retroactive policy accretions.

Automated billing cycles are used for both Providers and carriers. Provider accounts are debited if voluntary refunds are not received.

2. Medicare Recoveries – Billings to Providers and debits to accounts are automated. (This does not apply to capitated coverage.)

Casualty Recoveries – A strong assignment of rights and subrogation law enables SCDHHS to maximize casualty recoveries. Accident questionnaires are generated by the Medicaid claims processing system, using automated analysis of trauma diagnosis and surgical procedure codes. Recipients are asked, "How did you get hurt?" Most injuries are the result of accidents where no party is liable to pay. For those where repayment is likely, SCDHHS contacts insurers and Beneficiaries' attorneys to enforce its subrogation right.

13.0 QUALITY ASSESSMENT AND UTILIZATION MANAGEMENT REQUIREMENTS

All MCOs that contract with the SCDHHS to provide Medicaid MCO program services must have a system of Quality Assessment (QA) and Utilization Management (UM) process that meets the following standards:

1. Have a Quality Assessment system that:
 - a) Is consistent with applicable federal regulations
 - b) Provides for review by appropriate health professionals of the process followed in providing health services
 - c) Provides for systematic data collection of performance and patient results
 - d) Provides for interpretation of this data to the practitioners

- e) Provides for making needed changes.
2. Maintain and operate a Quality Assessment (QA) program which includes at least the following elements:
- a) Quality Assessment Program Description – A description of the QA program which outlines the MCOs mechanisms to monitor and evaluate Quality and appropriateness of patient care, pursue opportunities
 - b) Quality Assessment Program Description – A description of the QA program which outlines the MCO's mechanisms to monitor and evaluate Quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. The QA efforts should be health outcome oriented and rely upon data generated by the MCO as well as that developed by outside sources. The description must be organized and written so that staff members and practitioners can understand the program's goals, objectives, and structure, and should incorporate information from customer service, appeals and Grievances, medical management, credentialing, and provider relations. QA Staff – The QA plan developed by the MCO shall name a Quality director, manager, or coordinator responsible for the operations of the QA program. Such person shall be a healthcare professional (*i.e.*, registered nurse, physician, CPHQ), who has the necessary knowledge and skills to design, implement, and maintain ongoing healthcare Quality, patient safety, utilization, and clinical Risk management strategies, systems, processes, and associated activities. This person shall spend an adequate percentage of his or her time dedicated to QA activities to ensure the effectiveness of the QA program and be accountable for QA in all MCO Providers and Subcontractors. In addition, the medical director must have substantial regular involvement in QA activities.
 - c) Annual Quality Assessment Work Plan – The work plan should include, but not be limited to, the planned activities, objectives, time frames, or milestones for each activity, and the responsible staff member(s). This document should be updated frequently to reflect the progress on all activities.
 - d) Program Integrity Plan – SCDHHS (See Contract Section 11.1.)
 - e) QA Committee – The MCO's QA program shall be directed by a QA committee which has the substantial involvement of the medical director and includes membership from:
 - A variety of health professions (*e.g.*, pharmacy, physical therapy, nursing, etc.)
 - Participating network Providers in a variety of medical disciplines (*e.g.*, medicine, surgery, radiology, etc.). with emphasis on primary care including obstetric and pediatric representation
 - MCO management or Board of Directors
 - f) The QA Committee shall be located within the MCO such that it can be responsible for all aspects of the QA program.

- g) The QA Committee shall meet at least quarterly, produce dated and signed written documentation of all meetings and committee activities, and submit this information, on a quarterly basis, to the MCO Board of Directors, SCDHHS, and its authorized agents.
- h) The QA activities of MCO Providers and Subcontractors shall be integrated into the overall MCO QA program. The MCO QA program shall provide feedback to the Providers/Subcontractors regarding the integration of, operation of, and corrective actions necessary in Provider/Subcontractor QA efforts.
- i) The MCO shall have written procedures which addresses the MCO's approach to measurement, analysis, and interventions for QA activity findings. This procedure should include monitoring activities following intervention implementation. The measurement, analysis and interventions shall be documented in writing and submitted to the MCO Board of Directors and SCDHHS.
- j) The MCO shall make use of the SCDHHS utilization data, or their own utilization data, if equally or more useful than the SCDHHS utilization data, as part of the QA program.
- k) Quality Assessment and Performance Improvement Program (QAPI): The MCO shall have an ongoing quality assessment and performance improvement program for the services it furnishes to Members. In future contracts, pay-for-performance will be used to access the quality improvements measured in HEDIS and CAHPS surveys. At a minimum, the MCO shall:
 - Conduct performance improvement projects as described in this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement. This improvement should be sustained over time and have favorable effects on both health outcomes and enrollee satisfaction
 - Submit performance measurement data as described in this section.
 - Have in effect mechanisms to detect both underutilization and over utilization of services
 - Have in effect mechanisms to assess the Quality and appropriateness of care furnished to enrollees with special healthcare needs
 - Performance Measurements: Annually, MCOs shall measure and report to SCDHHS its performance using all NCQA defined HEDIS measures applicable to Medicaid by June 15th of the following calendar year. MCOs must use the correct HEDIS Technical Specifications for data collection and reporting for each year (*i.e.*, 2009 data would use HEDIS 2010 Technical Specifications).
 - Performance Improvement Projects (PIP): Annually, the MCO shall have an ongoing program of performance improvement projects (a minimum of two (2) projects) that focus on clinical and non-clinical areas, and involve the following:

- o Quantitative and Qualitative measurements of performance using standard objective Quality indicators
 - o Implementation of system interventions to achieve improvement in Quality
 - o Evaluation of the effectiveness of the interventions
 - o Planning and initiation of activities for increasing or sustaining improvement
 - o Each project must be completed in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregated to produce new information on Quality of care each year [42 CFR 438.240 (d) (2)].
- l) Annual Written Evaluation of the QA Program – An annual evaluation of the overall effectiveness of the QA and performance improvement program [42 CFR 438.240 (e) (2)].
- m) Report the MCO's QA program performance information to network Providers and Medicaid MCO Members at least annually.
3. Assist the SCDHHS in its Quality Assurance activities.
- a) 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 on-site medical chart reviews.
 - b) The MCO will arrange orientation meetings for physician office staff concerning on-site medical chart reviews.
 - c) 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.
 - d) MCO will facilitate training to its Providers.
 - e) 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 premises to inspect, audit, monitor or otherwise evaluate the performance of the MCOs or Subcontractors contractual activities.
 - f) 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
4. Assure that all persons, whether they are employees, agents, Subcontractors, or anyone acting for, or on behalf of, the Provider, are properly licensed and/or certified under applicable state law and/or regulations, and are eligible to

participate in the Medicaid/Medicare program. MCO shall also require the Subcontractor to check the Excluded Parties List Service administered by the General Services Administration when it hires any employee or contracts with another Subcontractor to ensure it does not employ individuals, or use Subcontractors, who are debarred, suspended, or otherwise excluded from participating in Federal procurement activities, and/or have an employment, consulting, or other agreement with debarred individuals for the provision of items and services that are significant to the Subcontractor's contractual obligation. The Subcontractor shall also report to the MCO any employees or Subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

- a) The MCO shall maintain a copy of all plan Providers current valid licenses to practice, or be able to access a copy within 72 hours, if requested.
 - b) The MCO shall have Policies and procedures for approval of new Subcontractors and termination or suspension of a Subcontractor.
 - c) The MCO shall have a mechanism for reporting Quality deficiencies which result in suspension or termination of a Subcontractor.
5. Have systems in place for coordination and continuation of care to ensure well managed patient care, including at a minimum:
- a) Written Policies and procedures for assigning every Medicaid MCO Member a Primary Care Provider.
 - b) Management and integration of healthcare through Primary Care Providers. The MCO agrees to 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.
 - c) A referral system for Medically Necessary, specialty, secondary and tertiary care.
 - d) 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.
 - e) Specific referral requirements for in and out of plan services. MCOs shall clearly specify referral requirements to Providers and Subcontractors and keep copies of referrals (approved and denied) in a central file or in the Medicaid MCO Member's medical record.
 - f) Assignment of an MCO 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.

6. Have systems for maintaining medical records for all Medicaid MCO Members in the plan, to ensure the Medical Record:
 - a) Is accurate, legible and safeguarded against loss, destruction, or unauthorized use and is maintained in an organized fashion for all individuals evaluated or treated, and is accessible for review and audit. 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.
 - b) Is readily available for MCO-wide QA and UM activities and provides adequate medical and clinical data required for QA/UM.
 - c) Has adequate information and record transfer procedures to provide Continuity of Care when Medicaid MCO Members are treated by more than one Provider.
 - d) Contain, at a minimum, the following items:
 - Patient name, Medicaid identification number, age, sex, and places of residence and employment and responsible party (parent or guardian)
 - Services provided through the MCO, date of service, service site, and name of service Provider
 - Medical history, diagnoses, prescribed treatment and/or therapy, and drug(s) administered or dispensed. The Medical Record shall commence on the date of the first patient examination made through, or by the MCO.
 - Referrals and results of specialist referrals
 - Documentation of emergency and/or after-hours encounters and follow-up
 - Signed and dated consent forms
 - For pediatric records (under 19 years of age) record of immunization status. Documentation of advance directives, if completed.
 - The documentation for each visit must include:
 - Date
 - Purpose of visit
 - Diagnosis or medical impression
 - Objective finding
 - Assessment of patient's findings

- o Plan of treatment, diagnostic tests, therapies and other prescribed regimens
 - o Medications prescribed
 - o Health education provided
 - o 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.
7. Submit Encounter Data as required, on a semi-monthly basis, in a format specified by SCDHHS.
- a) The MCO must report EPSDT and other preventive visit compliance rates.
 - b) All MCO contracts with network Providers/Subcontractors shall have provisions for assuring data required on the encounter report is reported to the MCO by the network Provider/Subcontractor.
 - c) For the purposes of reporting individuals by age group, the individual's age should be the age on the date of service.
8. Have written utilization management Policies and procedures which include, at a minimum:
- a) Protocols for 1) denial of services, 2) prior approval, 3) hospital discharge planning and 4) retrospective review of claims
 - b) Processes to identify utilization problems and undertake corrective action
 - c) An emergency room log, or equivalent method, specifically to track emergency room utilization and Prior Authorization (to include denials)
 - d) Processes to assure abortions comply with 42 CFR 441 subpart E-Abortions, and hysterectomies and sterilizations comply with 42 CFR 441 subpart F-Sterilizations.
9. Furnish Medicaid MCO Members with approved written information regarding the nature and extent of their rights and responsibilities as a Medicaid MCO Member of the MCO. The minimum information shall include:
- a) A description of the managed care plan
 - b) A current listing of practitioners providing health care
 - c) Information about benefits and how to obtain them
 - d) Information on the confidentiality of patient information
 - e) Grievance and appeal rights
 - f) Advance directive information as described in 42 CFR 417.436 and 489 subpart I
 - g) Eligibility and enrollment information

10. Maintain a Grievance and appeal system which:

- a) Has written Policies and procedures that are distributed to Medicaid MCO Members. These Policies and procedures must comply with the provisions of the MCO Contract.
- b) Informs Medicaid MCO Members they must exhaust the MCO's Appeal process prior to filing for a state fair hearing, and informs the Medicaid MCO members of the state fair hearing process and its procedures.
- c) Attempts to resolve grievances through internal mechanisms whenever possible and to contact the member by letter or telephone providing them with the MCO's resolution.
- d) Maintains a separate spreadsheet for oral and written Grievances and Appeals and records of disposition
- e) Provides to SCDHHS on a quarterly basis written summaries of the Grievances and Appeals logs which occurred during the reporting period to include:
 - Nature of Grievances or Appeals
 - Date of their filing
 - Current status
 - Resolutions and any resulting corrective action

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

- g) In the event a Medicaid MCO Member or Provider, acting on behalf of a Medicaid MCO Member, requests a State Fair Hearing, the MCO must transmit copies of all communication (written and electronic) to the SCDHHS MCO program manager concurrent with communication to the Medicaid MCO Member, the Provider, and the SCDHHS hearing officer.
 - h) Providers only have a derivative action for a state fair hearing, meaning that the Provider can only act on behalf of a Medicaid MCO Member with the Medicaid MCO Member's prior written consent. The MCO must have a process for Providers to allow Providers to seek legal remedies related to claims payment issues, whether through its Subcontract with the Provider or its Policies and procedures.
11. Allow for SCDHHS to evaluate each MCO's compliance with SCDHHS program Policies and procedures, identify problem areas and monitor the MCO's progress in this effort. At a minimum this must include, but is not limited to:
- a) SCDHHS review and approval of the MCO's written Quality Assurance and Improvement Plan. The MCO must submit any subsequent changes and/or revisions to its Plan to SCDHHS for approval on or before April 30th annually.
 - b) SCDHHS review and approval of the MCO's written Grievance and appeal Policies and procedures. The MCO must submit any subsequent changes

- and/or revisions to its Grievance and Appeal Policy and Procedures to SCDHHS for approval prior to implementation.
- c) SCDHHS review of monthly individual encounter/claim data. Encounter claim data shall be reported in a standardized format as specified by SCDHHS and transmitted through approved electronic media to SCDHHS.
 - d) SCDHHS review of quality measure reports. The reports will be submitted to SCDHHS in the format specified by SCDHHS.
 - e) SCDHHS review of the MCO's reports of Grievances, appeals, and resolution thereof.
 - f) 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.
12. Annually, SCDHHS will evaluate the MCO's compliance with QA standards through an annual comprehensive QA evaluation. The review will be performed by the External Quality Review Organization (EQRO) under contract with the SCDHHS. External quality assurance evaluation and EQRO responsibilities shall include:
- a) Conducting an annual review of the MCO. The CMS protocol, Monitoring Medicaid Managed Care Organizations, and SCDHHS-approved review standards will serve as a guide for the review. SCDHHS will receive a written report within 30 days following the on-site visit and will convey the final report findings to the MCO with a request for a POC, if warranted.
 - b) Effective January 1, 2013, verifying the most recent NCQA Accreditation survey and corresponding status. This survey is conducted every three years by NCQA and is required for plans to serve as an MCO. Prior to this date, verification of the most recent NCQA or URAC Accreditation survey and status with those organizations is required.
 - c) With SCDHHS staff, conducting workshops and trainings for MCO staff regarding the abstraction of data for the quality of care studies and other features of the annual QA evaluation.

13.1 NCQA HEDIS Reporting Measures

MCOs must use guidelines for HEDIS measures defined by NCQA for that respective measurement year. Measures must be submitted to SCDHHS by June 15th of the following calendar year (the reporting year). Data must be submitted in a SCDHHS approved format. A timeline for submitting HEDIS and CAHPS survey measures is published by the NCQA, and should be followed to ensure timely submission.

- Use the services of a contracted NCQA accredited compliance auditor or schedule a certified HEDIS Compliance auditor for the calendar year

- Collect measures January 1– December 31 Audit collection process by NCQA certified auditor
- Do a chart review for hybrid measures. In the event that a MCO does not have a contract with an NCQA-accredited vendor for auditing, this will be arranged by SCDHHS, and fees for auditing will be paid to SCDHHS to pay for auditing services. NCQA data software is available to help with data processing.
- Submit measures to NCQA
- MCOs must obtain the NCQA accreditation of excellence in the next review period (*No later than 2015*).

June 15th 2011: Submit finalized measures in an SCDHHS approved format.

14.0 MARKETING / ADVERTISING AND MEDICAID MCO MEMBER EDUCATION

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

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

SCDHHS defines Marketing/media Materials as those materials that:

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

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

- Brochures
- Fact sheets
- Posters

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

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

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

14.1 General Marketing/Advertising and Medicaid MCO Member Education Policies

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

Violation of any of the listed Policies shall subject the MCO to sanctions, including suspension, fine and termination, as described in Section 13 of the MCO contract and as determined by the SCDHHS. The MCO may appeal these actions within 30 calendar days in writing to the SCDHHS' Appeals Department.

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

A. Permitted Activities

1. The MCO is allowed to offer nominal “give-a-way items 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. 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. These “give-a-way items” must have been prior approved by SCDHHS.
2. “Value Added Items and Services (VAIS).” Are permitted to be given to Medicaid MCO Members as incentives or rewards for “healthy behaviors”. These items can have a value of more than \$25.00 and must be limited to the purchase of healthcare related products. Gift cards from the MCO or its designee cannot allow the purchase of items such as, but not limited to, alcohol, tobacco, ammunition, etc.) It is permissible for Medicaid MCO Members to use the Gift Cards for transportation, help in paying electrical bills, diapers, formulary etc. Any clarifying questions on other health items or services the MCO shall contact its Program Manager prior to the use of gift cards.
3. The Marketing representative is responsible for providing the Medicaid MCO Member with information on participating PCPs and assisting in determining if his or her current physician is a member of the MCO’s network.
4. Any claims stating that the MCO is recommended or endorsed by any public or private agency or organization, or by any individual must be prior approved by SCDHHS and must be certified in writing by the person or entity that is recommending or endorsing the MCO.
5. The MCO is allowed to directly and/or indirectly conduct Marketing/advertising activities in a doctor’s office, clinic, pharmacy, hospital or any other place where healthcare is delivered, with the written consent of the Provider. This also includes government facilities, such as local offices of the South Carolina Department of Health and Human Services, the Department of Social Services, the Department of Health and Environmental Control, Head Start and public schools. The use of government facilities is only allowed with the written permission of the government entity involved. Any stipulations made by the Provider or government entity must be followed (allowable dates, times, locations, etc.).
6. All Marketing/advertising activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of Beneficiaries or the general community.
7. The MCO may provide approved Marketing/advertising and educational Materials for display and distribution by Providers. This includes printed material and audio/video presentations.

8. Upon request by a Medicaid Beneficiary, Marketing representatives may provide him or her with information (excluding an enrollment form) about the MCO to give to other interested Medicaid Beneficiaries (i.e., business card, Marketing brochure).

B. Activities Which Are Not Permitted

1. The MCO is prohibited from distributing enrollment forms or aiding a Medicaid Beneficiary in filling out or transmitting an Enrollment form in any way.
2. When conducting Marketing/advertising activities, the MCO shall not use their personal or Provider-owned communication devices (i.e., telephone or cell phone, fax machine, computer) to assist a person in enrolling in a health plan.
3. The MCO shall not make any claims or imply in any way that a Medicaid Beneficiary will lose his or her benefits under the Medicaid program or any other health or welfare benefits to which he/she is legally entitled, if he/she does not enroll with the MCO.
4. The MCO cannot make offers of material or financial gain (such as gifts, gift certificates, insurance policies) to Medicaid Beneficiaries to induce plan Enrollment.
5. The MCO (and any Subcontractors or representatives of the MCO) shall not engage in Marketing/advertising practices or distribute any Marketing/advertising Materials that misrepresent, confuse, or defraud Medicaid Beneficiaries, Providers, or the public. The MCO shall not misrepresent or provide fraudulent misleading information about the Medicaid program, SCDHHS and/or its policies.
6. The MCO cannot discriminate on the basis of a Medicaid MCO Member health status, prior health service use or need for present or future healthcare services. Discrimination includes, but is not limited to, expulsion or refusal to re-enroll a Medicaid MCO Member except as permitted by Title XIX.
7. The MCO's Marketing representatives may not solicit or accept names of Medicaid Beneficiaries from Medicaid Beneficiaries or Medicaid MCO Member for the purpose of offering information regarding its plan.
8. The MCO may only market in the Beneficiary's residence if they obtain a signed statement from the Medicaid Beneficiary; giving permission for the MCO's representative to conduct a home visit for the sole purpose of Marketing activities.
9. The MCO is prohibited from comparing their organization/plan to another organization/plan by name.

14.2 Medicaid Beneficiary and MCO Member Contact

- A. The MCO is not allowed to directly or indirectly, conduct door-to-door, telephonic, or other "cold call" Marketing/advertising activities. This includes initiating contact with a Medicaid MCO Member of the public or Beneficiary at a Marketing event.

- B. The MCO is not allowed to initiate direct contact (defined as a face-to-face interaction where communication takes place) with Medicaid Beneficiaries for purposes of soliciting Enrollment in their plan.
- C. The MCO may not market directly to Medicaid applicants/Beneficiaries in person or through direct mail advertising or telemarketing.
- D. The MCO may contact Medicaid MCO Members who are listed on their monthly Medicaid MCO Member listing to assist with Medicaid recertification/eligibility.
- E. The MCO is not allowed to directly, indirectly or use a third party vendor, contact Disenrollees listed on their monthly Medicaid MCO Member listing.

14.3 Beneficiary Marketing and Member Education Materials/Media

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

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

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

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

- MCOs can, with SCDHHS written prior approval, utilize mass media which includes, but is not limited to, public service announcements such as radio and television spots (air time paid for by MCO), advertising in newspapers, magazines, church bulletins, billboards, and buses.
- All Marketing/advertising Materials/media (including Internet and social media sites) must include the SC Healthy Connections (SCHC) logo.
- Promotional Materials to include items identified as "give-a-ways," which contain the MCO's logo must also contain the SCHC logo. Current stock not containing the SCHC logo may be used until January 1, 2012; however, all stock ordered on or after February 3, 2011 must contain the SCHC logo.
- Educational Materials and third party publications, such as CDC guidelines, dietary information, Disease Management, etc. do not require the SCHC logo so long as the MCO's name, logo and/or phone number are not present. If the MCO

logo and/or phone number is present, the SCHC logo must also be present. Current stock, not containing the SCHC logo may be used until September 1, 2011; however, all stock ordered on or after February 3, 2011 must contain the SCHC logo.

- All logos (SCHC and MCO) and associated phone numbers must be proportional in size and location.
- MCOs can passively distribute approved Marketing/advertising and educational Materials, with written authorization from the entity responsible for the distribution site, to Medicaid Beneficiaries and Medicaid MCO Members. Passive distribution is defined as the display of materials with no MCO Marketing or education staff present.
- MCOs may mail SCDHHS approved Marketing/advertising and educational Materials within its approved Service Areas. Mass mailings directed to only Medicaid Beneficiaries are prohibited
- MCOs' network Providers can correspond with Beneficiaries concerning their participation status in the Medicaid Program and the MCO. These letters may not contain MCOs' Marketing/advertising/education Materials or SCDHHS Enrollment forms. Letters must be developed, produced, mailed and/or distributed directly by the network Provider's office at their expense. This function cannot be delegated by the Provider, to the MCO or an agent of the MCO. In addition, the use of these letters must be in accordance with SC Department of Insurance Policies and regulations.
- The MCO shall ensure that all materials are accurate, are not misleading or confusing, and do not make material misrepresentations.
- All materials shall be submitted to be reviewed and approved for readability, content, reading level, and clarity by SCDHHS or its designee, prior to use or distribution.
- The MCO shall ensure that all written material will be written at a grade level no higher than the seventh (7th) grade (7.9 on the reading scale) or as determined appropriate by SCDHHS.
- The MCO shall ensure that appropriate foreign language versions of all Marketing/advertising and education Materials are developed and available to Medicaid Beneficiaries and Medicaid MCO Members. Foreign language versions of materials are required if the population speaking a particular foreign (non-English) language in a county is greater than ten (10) percent. If counties are later identified, SCDHHS will notify the MCO. These materials must be approved, in writing, by SCDHHS. Affidavits of accuracy and reading level compliance by a professional translation service must accompany all foreign language translations and be submitted with the approval request.
- The MCO shall issue a certificate or evidence of coverage and/or Medicaid MCO Member handbook which describes/contains at a minimum, the following:

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

- When the MCO identifies its MCO Medicaid Beneficiaries who have visual and/or hearing impairments, an interpreter must be made available.
- The MCO's written material shall include its current network Provider list, which includes names, area of specialty, address, and telephone number(s) of all participating Providers, groups and facilities including primary care, specialty care, hospitals, clinics, pharmacies, ancillary Providers (such as labs and x-ray), DME Providers, and all other required services Providers. It shall also include a map or description of the MCO's Service Area.
- The MCO's written material must include a definition of the terms "Emergency Medical Care" and "urgent medical care" and the procedures on how to obtain such care within and outside of the MCO's Service Area.

- The MCO must provide a description of its Family Planning Services and services for communicable diseases such as TB, STD, and HIV/AIDS. The description must include a statement of the Medicaid MCO Member's right to obtain Family Planning Services from the plan or from any approved Medicaid enrolled Provider. Also included must be a statement of the Medicaid MCO Member's right to obtain TB, STD, HIV/AIDS services from any state public health agency.
- Summary documents and brochures must include a statement that the document may contain only a brief summary of the plan and that detailed information can be found in other documents, e.g., Evidence of Coverage, or obtained by contacting the plan.

14.4 Marketing Events and Activities

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

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

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

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

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

14.5 Focus Groups and Member Surveys

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

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

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

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

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

14.6 Member Services

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

- Definitions of appropriate and inappropriate utilization of services
- Instructions on how to access services

- Instructions on how to select a primary care physician
- Information on how to access out-of-network (non-participating) providers
- Information on how to access emergency care (in- or out-of-area)
- Explanation of the process for Prior Authorization of services
- Toll-free telephone numbers for member services
- Explanation of how to authorize the Provider to release medical information to the federal and state governments or their duly appointed agents

14.7 Medicaid MCO Program Identification (ID) Card

The MCO shall issue an identification card for its Medicaid MCO members to use when obtaining Core Benefits and any approved Additional Services. To ensure immediate access to services, the MCO shall establish appropriate mechanisms, procedures and Policies to identify its Medicaid MCO Members to Providers until the Medicaid MCO Member receives its MCO ID card from the MCO. A permanent MCO ID card must be issued by the MCO within 14 calendar days of selection of a PCP by the Medicaid MCO Member or date of receipt of Enrollment data from SCDHHS, whichever is later.

The MCO is responsible for issuing an ID card that identifies the holder as a Medicaid MCO Member. Effective January 1, 2013 the MCO must begin using the Medicaid Member's identification issued by SCDHHS.

The ID card must include at least the following information:

- MCO name
- A 24 hour telephone number for Medicaid MCO Members use in urgent or emergency situations or to obtain any other information
- Primary care physician's name
- Medicaid MCO Member name and Medicaid identification number
- Expiration date (optional)
- Toll-free telephone numbers
- SC Healthy Connections logo must be in color

14.8 Enrollment

All Enrollment activities are to be exclusively conducted by the Enrollment broker. This includes distribution of forms, assistance to Medicaid Beneficiaries and transmittal of Enrollment information to the Enrollment broker and SCDHHS.

No distribution of Enrollment forms is allowed by an MCO or employee/agent of an

MCO. Distribution is defined as making the Enrollment form available directly or indirectly through the MCO or representative of the MCO.

14.9 Enrollment Incentives

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

15.0 PROGRAM INTEGRITY POLICIES AND PROCEDURES – MANAGED CARE FRAUD AND ABUSE COMPLAINTS AND REFERRALS

To establish policy for coordination and referral of complaints made against healthcare providers providing services under a managed care plan and beneficiaries enrolled in a managed care plan, in accordance with 42 CFR 455.

The Division of Program Integrity (PI) and the Division of Managed Care will work jointly with the managed care plans and medical home networks providing services to the South Carolina Medicaid populations in order to ensure that all complaints for fraud and abuse are reviewed and investigated in a timely manner and that fraud referrals are made when appropriate.

15.1 Coordination Involving SCDHHS Fraud Hotline Complaints

If the SCDHHS Fraud Hotline, Division of Program Integrity, Department of Recipient Utilization, receives a complaint about an MCO beneficiary/member's eligibility for Medicaid, the complaint is entered into the Hotline Complaint Log within three state working days and will be investigated by the Recipient Utilization intake worker.

If the SCDHHS Fraud Hotline receives a complaint about an MCO beneficiary/member's utilization of benefits, the intake worker will refer the complaint via secure e-mail or SCDHHS secure portal (only after the MCO has established the link with the PI portal Webmaster) to the MCO Compliance Officer at the MCO.

If SCDHHS Fraud Hotline receives a complaint about a provider with indications they are in a managed care network, the complaint is referred to the appropriate Program Integrity Department Supervisor and the MCO Compliance Officer at the MCO using secure e-mail or SCDHHS secure portal (only after the MCO has established the link with the PI portal Webmaster) for preliminary screening for fraud and abuse.

The Department of Recipient Utilization will capture data for complaints made against beneficiaries receiving services under a managed care plan by electronically checking the Referral type “MCO” box in our Case Management System on the Medicaid Complaint Form.

15.2 Coordination for Fraud and Abuse Complaints Received by Managed Care Organizations

- If the MCO receives a complaint about a member’s eligibility for Medicaid, the complaint is referred to Program Integrity. The referral is made within three state working days using either the Fraud Hotline number at 1-888-364-3224, the Fraud Fax number at (803)255-8224, the Fraud Hotline via the Internet at fraudres@scdhhs.gov or the SCDHHS secure portal (only after the MCO has established the link with the PI portal Webmaster).
- If the MCO receives a complaint about a member’s utilization of benefits, the complaint is handled internally in accordance with the Plan’s fraud and abuse / program integrity plan.
- If the MCO receives a complaint against a health care provider or subcontractor in its network, the MCO will investigate in accordance with its fraud and abuse/ program integrity plan.

15.3 Fraud and Abuse Referrals

- If a complaint or the findings of a preliminary investigation give the MCO reason to suspect that fraud or abuse of the Medicaid program has occurred, the MCO must immediately (within one working day) report this information to the Division of Program Integrity using either the Fraud Hotline number at 1-888-364-3224, the Fraud Fax number at (803)255-8224, the Fraud Hotline via the Internet at fraudres@scdhhs.gov, or the SCDHHS secure portal (only after the MCO has established the link with the PI portal Webmaster). Any suspicion or knowledge of fraud and abuse would include, but not be limited to, the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent, on the part of members, employees, providers, or subcontractors. Potential fraud on the part of a provider would include either participating or non-participating providers in the MCO’s plan.
- The MCO should submit all relevant information about the case, including its findings and the details of its investigation. For each case of suspected provider fraud and abuse that is referred, the following information should be included:
 1. Provider’s name and number
 2. Source of the complaint
 3. Type of provider
 4. Nature of the complaint

5. Approximate range of dollars involved
 6. Legal and administrative disposition of the case
- SCDHHS intake worker will log the complaint and refer the case to the appropriate Program Integrity Department Supervisor. The case will be reviewed and a decision made to close the case, pursue as a recovery, or refer the case to the Medicaid Fraud Control Unit in the SC Attorney General's Office, either during its monthly meeting or as soon as possible in urgent cases.
 - Upon suspicion of Medicaid fraud on the part of a beneficiary/member enrolled in an MCO, the MCO will refer the complaint to the Division of Program Integrity with all supporting evidence so the complaint can be logged and investigated by the SCDHHS Department of Recipient Utilization's intake worker. The case will be reviewed and a decision will be made to close the case, pursue as a recovery, or refer the case to the Medicaid Recipient Fraud Unit in the SC Attorney General's Office, either during its monthly meeting or as soon as possible in urgent cases.
 - SCDHHS will inform the Division of Managed Care when cases against providers and members in the managed care program, are referred by SCDHHS to the SC Attorney General's Office for fraud, as well as when the case results in a criminal conviction, exclusion, and/or termination.
 - For providers in circumstances where credible allegations of fraud result in the withholding of the provider's fee-for-service payments, SCDHHS will provide this information to the appropriate MCO.

15.4 Reporting Requirements: MCOs

- Once a month, each MCO's Compliance or Integrity Unit must report to the PI Division Director on the status of its fraud and abuse activities including:
 1. A list of all investigations and/or audits of providers and beneficiaries suspected of fraud, abuse, or other improper use of benefits
 2. All fraud and abuse complaints received by the MCO in the previous month and the disposition
 3. The results of any data mining activities or other internal monitoring of provider claims and utilization of services

The report should include the name of the provider or beneficiary, the NPI number or beneficiary number, reason for investigation, status of investigation, and the outcome or findings.

- This report should be sent in accordance with the process described in the Information Sharing section. Each MCO should provide the report monthly regardless of whether it has any new activities to report.

15.5 Reporting Requirements: SCDHHS

- Program Integrity will provide to the MCO compliance officers a monthly report extracted from its Case Management System on the number of fraud complaints received on managed care members and the number referred to the Medicaid Recipient Fraud Unit.
- SCDHHS will report on the number of managed care providers referred either to the MCOs and/or Program Integrity for preliminary investigation.
- SCDHHS will report quarterly the names and NPIs of providers where both the MCO and the Division of Program Integrity have concurrent investigations.

15.6 Excluded Providers

- Division of Program Integrity will send copies of all provider exclusion, termination, and reinstatement letters to the Division of Care Management once a month to share with all Plans. Provider exclusion letters will be based on fraud convictions, loss of license, patient abuse, and other reasons. Reinstatement letters will indicate provider removal from the SCDHHS exclusion list. Once a provider is removed from the exclusion list, he or she must reapply to become a Medicaid provider; it is not automatic.

Note: SCDHHS updates its website monthly with names of excluded individuals and entities. The MCOs should use this website for on-going information about exclusions.

15.7 Information Sharing

- Once the secured Portal link has been established between SCDHHS Program Integrity Webmaster and the individual MCO, it may be used for sharing all beneficiary/member and provider information in the context of fraud and abuse reviews and referrals.
- The MCO may also call the Fraud Hotline at #888-364-3224.
- The MCO may also fax the Fraud Fax at #803-255-8224.
- The MCO may also email the data to the Fraud Hotline via the Internet at fraudres@scdhhs.gov.
- In some cases, the MCO representative may also send information to the PI Division via the SCDHHS MCO liaison.

16.0 Ownership Disclosure

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

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

MCOs are required to replace the previous Ownership Disclosure Form (1513) with the new version (1514) no later than April 1, 2013. MCOs are required to have all subcontractors fill out an ownership disclosure form prior to execution of the contract (agreement). Additionally, MCOs must verify the Subcontractor’s information at least yearly based on the date of execution of the contract (agreement).

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

17.0 INCENTIVE PLANS

17.1 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 only if: (1) no specific payment can be made directly or indirectly under a physician incentive plan to a physician or physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual enrollee; and (2) the stop-loss protection, enrollee survey, and disclosure requirements of this section are met.

The MCO must maintain adequate information specified in the PIP regulations and make available to the SCDHHS, if requested, in order that the SCDHHS may

adequately monitor the MCO's PIP if applicable. The disclosure must contain the following information in detail sufficient to enable the SCDHHS to determine whether the incentive plan complies with the PIP requirements:

1. Whether services not furnished by the physician group are covered by the incentive plan. If only the services furnished by the physician or physician group are covered by the incentive plan, disclosure of other aspects of the plan need not be made.
2. The type of Incentive Arrangement; for example, withhold, bonus, capitation
3. If the incentive plan involves a withhold or bonus, the percent of the withhold or bonus
4. Proof that the physician or physician group has adequate stop-loss protection, including the amount and type of stop-loss protection
5. The panel size and, if patients are pooled, the approved method used
6. In the case of capitated physicians or physician groups, Capitation Payments paid to primary care physicians for the most recent calendar year broken down by percent for Primary Care Services, referral services to specialists, and hospital and other types of Provider (for example, nursing home and home health agency) services
7. In the case of those prepaid plans that are required to conduct Beneficiary surveys, the survey results (which must be provided in a timely manner to Medicaid Recipients upon request)

The disclosure requirements numbers 1 through 5 must be provided prior to contract approval and upon the effective date of its contract renewal. Disclosure requirement number 6 must be provided for the previous calendar year by April 1 of each year.

The MCO must disclose this information to the SCDHHS when requested. The MCO must provide the capitation data required no later than three months after the end of the calendar year. The MCO will provide to the Beneficiary upon request whether the prepaid plan uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement, whether stop-loss protection is provided, and the survey results of any enrollee or disenrollee surveys conducted.

17.2 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.

17.3 Recipient Survey

Federal regulations 42 CFR 417.479(g)(1) requires that organizations that operate incentive plans that place physicians or physician groups at substantial financial risk (SFR) must conduct surveys of enrollees. Surveys must include either all current Medicaid enrollees in the MCO's plan and those that have disenrolled other than because of loss of eligibility or relocation, or choose to conduct a valid statistical sample.

According to 42 CFR 417.479(g)(iv), enrollee surveys must be conducted no later than one year after the effective date of the contract and at least annually thereafter. As long as physicians or physician groups are placed SFR for referral services, surveys must be conducted annually. The survey must address enrollees and disenrollees satisfaction with the quality of services, and their degree of access to the services. Medicare contracting MCOs will meet the survey requirement via a CMS sponsored survey conducted by the Agency for Health Care Policy and Research through their Consumer Assessments of Health Plans Study (CAHPS) process. SCDHHS has the authority to utilize the Medicaid version of CAHPS to meet the survey requirement. MCOs, upon completion of approved survey tool, will be expected to compile, analyze and summarize survey data within 120 days and submit the results to the SCDHHS.

Note: If Disenrollment information is obtained at the time of Disenrollment from all Beneficiaries, or a survey instrument is administered to a sample of disenrollees, your current method will meet the disenrollee survey requirements for the contract year.

17.4 Sanctions

A. Withholding of Federal Financial Participation (FFP)

Section 1903(m) of the Act specifies requirements that must be met for states to receive Federal Financial Participation (FFP) for contracts with MCOs. Federal regulation 42 CFR 434.70(a)(2002, as amended, sets the conditions for FFP. Federal funds will be available to Medicaid for payments to MCOs only for the periods that the MCOs comply with the PIP requirements in 42 CFR 417.479(d)-(g), (h)(1), (h)(3), and 417.479(l) requirements related to Subcontractors. These regulations cover: 1) the prohibition of physician payments as an inducement to reduce or limit covered Medically Necessary Services furnished to an individual

enrollee, 2) proper computation of substantial financial risk, 3) physician stop-loss protection, 4) enrollee survey requirements, and 5) disclosure requirements.

Federal regulations 42 CFR 434.70(b) provides that CMS may withhold FFP for any period during which the State fails to meet the State plan requirements of this part.

B. Intermediate Sanctions and/or Civil Money Penalties

Federal Regulations 42 CFR 438.700(a) states that intermediate sanctions (42 CFR 438.702, types of intermediate sanctions) may be imposed on a MCO with a risk comprehensive contract which fails to comply with any of the requirements of 417.479(d)-(g), or fails to submit to SCDHHS its physician incentive plans as required or requested in 42 CFR 422.208 and 422.210.

In accordance with 42 CFR 1003.103(f)(1)(vi), the OIG may impose a Civil Monetary Penalty of up to \$25,000 for each determination by CMS that a contracting organization has failed to comply with 417.479(d)-(g) and 434.70. Civil Monetary Penalties may be imposed on the organization in addition to, or in place of the imposed sanctions.

17.5 Definitions for Physician Incentive Plan Requirements

Physicians Incentive Plan – Any compensation arrangement between a MCO and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services furnished to Medicaid Beneficiaries enrolled in the MCO.

Physician Group – A partnership, association, corporation, individual practice association (IPA), or other group that distributes income from the practice among members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

Intermediate Entity – Entities which contract between an MCO or one of its Subcontractors and a physician or physician group. An Individual Practice Association (IPA) is considered an intermediate entity if it contracts with one or more physician groups in addition to contracting with individual physicians.

Substantial Financial Risk – An incentive arrangement based on referral services that place the physician or physician group at risk for amounts beyond the risk threshold. The risk threshold is 25 percent.

Bonus – A payment that a physician or entity receives beyond any salary, fee-for-service payment, capitation, or returned withhold. Quality bonuses and other compensation that are not based on referral levels (such as bonuses based solely on

care, patient satisfaction or physician participation on a committee) are not considered in the calculation of substantial financial risk, but may be revisited at a later date.

Capitation – A set dollar payment per patient per unit of time (usually per month) that is paid to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

Payments – The amount a MCO pays physicians or physician group for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of referral services (such as withhold amounts, bonuses based on referral levels, and any other compensation to the physician or physician group to influence the use of referral services). Bonuses and other compensation that are not based on referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of this subpart.

Referral Services – Any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish.

Risk Threshold – The maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. The risk threshold is 25 percent.

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

18.0 PUBLIC REPORTING BURDEN

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0700. The time required to complete this information collection is estimated to average 100 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection.

If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, P.O. Box 26684, Baltimore, Maryland, 21207 and to the Office of the Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C., 20503.

CMS will accept copies of state-mandated submissions in lieu of the Disclosure Form if such submissions include all the necessary elements of information as required by CMS and the statute. MCOs may maintain records supporting the Disclosure Forms in any

format, as long as these records sufficiently document the disclosure information the MCO submits and are available for inspection by appropriate regulators.

19.0 PAY FOR PERFORMANCE PROCESS

19.1 Capitation Rate Calculation Sheet (CRCS Reporting)

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, commencing 10/1/09, MCOs are required to submit quarterly Capitation Rate Calculation Sheet (CRCS) reports to SCDHHS. This is to be done in a timely, complete and accurate manner. The data elements, and other requirements for the report format, can be found in the MCO Reports Companion Guide. CRCS reports are due within 105 days of the end of each calendar quarter. The following reporting schedule is used:

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

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

Effective with the fourth (4th) quarter 2011 submission of the CRCS Report (reporting period October 1 to December 31, 2011) due no later than April 15th of the following year (16th in a leap year), the MCO must ensure the CRCS report can be verified to a degree of at least 97% completeness for all claims (i.e., an incompleteness rate means no more than 3% variance in utilization per 1,000 as outlined in the Milliman letter to the MCO.). SCDHHS will use the MCO's Encounter data, or other method of data completion verification deemed reasonable by SCDHHS, to verify the completeness of the CRCS report in comparison to the MCO's Encounter claims. SCDHHS reserves the right to change the method of data completion verification upon reasonable advance notice to the MCO.

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

In the event the MCO's CRCS report fails to meet the standards described above, SCDHHS will assess the penalty on a progressive sliding scale up to a maximum of one quarter percent (0.25%) as explained below:

In the case of 94% or less completeness (utilization per 1,000) the full one quarter (0.25%) percent will be assessed against the capitation payment paid to the MCO for each month of the reporting year.

In the case of 94% to 94.99999% of completeness (utilization per 1,000) SCDHHS will assess 0.125% of the capitation rate for each month of the reporting year.

In the case of 95% to 95.99999% of completeness (utilization per 1,000) SCDHHS will assess 0.0833% of the capitation rate for each month of the reporting year.

In the case of 96% to 96.99999% of completeness (utilization per 1,000) SCDHHS will assess 0.0625% of the capitation rate for each month of the reporting year.

All penalties will be applied through a gross level adjustment no less than forty-five days after SCDHHS or its designee reports the year-to-date results.

20.0 INDEX OF REQUIRED FILES, REPORTS, AND FORMS

This chart is a summary listing of: 1) all files to be submitted by MCOs to SCDHHS, 2) all reports to be submitted by MCOs to SCHHHS, 3) all files to be submitted by SCDHHS to MCOs, and 4) all applicable SCDHHS forms to be used by MCOs in the conduct of business. A file is defined as a set of related records compiled in a specified format. A report is defined as a written document containing predefined data elements or record of information and a form is defined as a document used to collect or report information. Copies of all file formats, reports, and forms can be found in the MCO Reports Guide. The medium of all files and reports shall be electronic and follow the specifications noted in Section 13.43 Software Reporting Requirement of the 2008 MCO Contract **or** MMIS guidelines and requirements (as applicable).

All files/reports with a frequency of "monthly" are due no later than the 15th (fifteenth) day after the end of the reporting month. The exceptions to this requirement are 1) Third Party Liability File, which is due by the 8th (eighth) day of the month and 2) encounter files, which can be submitted no later than the 25th (twenty-fifth) of the following month with the exception if the 25th of the following month is a Friday the MCO must submit the encounter data on the Thursday before (24th). MCOs are encouraged to file their encounter data throughout the month. However, encounter data shall not be submitted on a Friday. All files/reports with a quarterly frequency are due no later than the 30th (thirtieth) day after the end of the reporting quarter. All annual reports are due no later than the 90th (ninetieth) day after the end of the reporting year period. If the 15th (fifteenth), 30th (thirtieth), or 90th (ninetieth) day of the month falls on a weekend or state

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holiday, the reports will be due the last business day before the 15th (fifteenth), 30th (thirtieth), or 90th (ninetieth) day of the month in which the report is due.

Submission of all reports, (including monthly, quarterly, annual, ad-hoc, corrective action plans, or any other reports required by SCDHHS) are due no later than 12 PM (Noon) Eastern Time (ET) on the due date.

Summary of Required Files, Reports, and Forms		
General Instructions		
Data Transmission Requirements		
Security Requirements For Users of SCDHHS Computer Systems		
Use of Control Files for EDI Transfers		
Void Instructions for HIC, HOSP or DRUG Encounters		
MCO Files to SCDHHS	Frequency	Recipient
Encounter Data Submission Process	NA	NA
MCO HCFA 1500 Encounter Rec (ambulatory encounters) File	Monthly*	SCDHHS MMIS
MCO Hospital Encounter Rec (hospital encounters) File	Monthly*	SCDHHS MMIS
MCO Drug Encounter Rec INP – 3 (drug encounters) File	Monthly*	SCDHHS MMIS
Capitated Payment Summary Layout	Monthly*	SCDHHS MMIS
Third Party Liability File Layout	Monthly	SCDHHS MMIS
MCO Provider Identification Record File Layout (Non- Medicaid Providers)	Monthly	SCDHHS MMIS
MCO Reports to SCDHHS	Frequency	Recipient
Model Attestation	To be Attached to all Reports	Recipient of Report
Network Providers and Subcontractors Listing Spreadsheet Requirements	Monthly	Department of Managed Care, Quality Programs
Grievance Log with Summary Information	Collected Monthly and Reported Quarterly	Department of Managed Care, Quality Programs
Appeals Log with Summary Information	Collected Monthly and Reported Quarterly	Department of Managed Care, Quality Programs
Maternity Kicker Payment Notification Log	Monthly	Department of Managed Care, Quality Programs
Newborn Enrollment Error Form	Monthly	Department of Managed Care, Quality Programs

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Summary of Required Files, Reports, and Forms		
Low Birth Weight Kicker Payment Log	Quarterly	Department of Managed Care, Quality Programs
CRCS Report (Composite & Maternity)	Quarterly	Department of Managed Care, Quality Programs
Claims Payment Report	Monthly	Department of Managed Care, Quality Programs
FQHC/RHC Data Files	Quarterly	Division of Ancillary Reimbursements
Quality Assurance (QA): 1. QA Plan 2. QA Plan of Correction 3. Performance Improvement Projects 4. HEDIS Reporting Measures	As required As required As required Annually	Department of Managed Care, Quality Programs
Quality Initiatives: 1. PCMH 2. BOI: a. SBIRT b. Centering Program c. Nurse Family Partnership Premature/Low Birth Weight	Quarterly Quarterly Quarterly Quarterly Semi-Annually	Department of Managed Care
Member Satisfaction Survey	Annually	Department of Managed Care, Quality Programs
GME Report	Quarterly	Division of Acute Care Reimbursement
WRAP Summary Encounter Layout	Quarterly	Division of Ancillary Reimbursements
SCDHHS Files to MCOs	Frequency	Recipient
Managed Care MLE Record Description – MCO Member Listing Record	Monthly	MCO
Output Record for Provider Identification File	Monthly	MCO
Output Encounter Data Layout for Pharmacy Services	One business day after processing	MCO
Output Encounter Data Layout for Ambulatory Services	Once business day after processing	MCO
Output Encounter Data Layout for Hospital Services	Once business day after processing	MCO
Record for EPSDT Visits and Immunizations	Monthly	MCO
Claims Record Description	Monthly	MCO
MCO/MHN Recipient Review Recertification File	Monthly	SCDHHS MMIS

Summary of Required Files, Reports, and Forms		
Daily Newborn Enrollee File	Daily	SCDHHS MMIS
Other Files to be received (no examples in this Guide): 1. Carrier Codes File 2. Contact Rates File 3. Fee Schedule File 4. Recertification File 5. 820 File	Monthly	MCO
MCO/MHN/MASIMUS Sync File Layout	At least Monthly	MCO/SCDHHS
Form Listing		
Sample WIC Referral Form		
Hysterectomy Acknowledgement Form (Acknowledgement of Receipt of Hysterectomy Information)		
Instructions for Completion of Hysterectomy Acknowledgement Form		
Form Listing		
Individuals Informed Consent to Non-Therapeutic Sterilization for Medicaid Recipients Form (DHHS 1723)		
Instructions for Completion of Sterilization Consent Form		
Abortion Statement		
Instructions for Completion of Abortion Statement		
Request for Medicaid ID Number Form		

*Encounter files may be submitted more frequently than monthly. See the MCO Reports Guide for instructions.

21.0 DEFINITION OF TERMS

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

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

Action – As related to Grievance, either (1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of the Contractor to act within the timeframes provided in §9.7.1 of the MCO Contract; or (6) For a resident of a rural area with only one MCO, the denial of a Medicaid MCO Member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the Contractor's network.

Additional Services – Services provided by MCO which are non-covered by the SCDHHS under the South Carolina State Plan for Medical Assistance.

Administrative Days – Inpatient hospital days associated with nursing home level patients who no longer require acute care and are waiting for nursing home placement. Administrative Days must follow an acute inpatient stay.

Applicant – An individual seeking Medicaid eligibility through written application.

Beneficiary – An individual who is Medicaid Eligible and meets the criteria to enroll in the Managed Care Organization or Medical Homes Network Programs.

Capitation Payment – A payment SCDHHS makes periodically to the MCO on behalf of each MCO Medicaid Member enrolled under a contract for the provision of medical services under the South Carolina State Plan for Medical Assistance. SCDHHS makes the payment regardless of whether the particular MCO Medicaid Member actually receives services during the period covered by the payment.

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

Certified Nurse Midwife/Licensed Midwife – A certified nurse midwife must be licensed and certified to practice as an advanced practice registered nurse by the Board of Nursing under the South Carolina Department of Labor, Licensing and Regulations. A licensed midwife is a layperson who has met the education and apprenticeship requirements established by DHEC.

Certified Registered Nurse Anesthetist (CRNA)/Anesthesiologist Assistant (AA) – A CRNA must be licensed to practice as a registered nurse in the state in which he or she is rendering services **and** currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. An AA must be licensed to practice as an anesthesiologist assistant in the state in which he or she is rendering services. A CRNA is authorized to perform anesthesia services only and may work independently or under the supervision of an anesthesiologist.

CFR – Code of Federal Regulations.

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

CMS – Centers for Medicare and Medicaid Services

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

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

Cold-Call Marketing – Any unsolicited personal contact by the MCO with a potential member for the purpose of Marketing.

Comprehensive Risk Contract – A Risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services: (1) Outpatient hospital services; (2) Rural health clinic services; (3) FQHC services; (4) Other laboratory and X-ray services; (5) Nursing facility (NF) services; (6) Early and periodic Screening, diagnostic, and treatment (EPSDT) services; (7) Family Planning Services; (8) physician services; and (9) Home health services.

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

Continuity of Care – Maintaining the same healthcare provider for (i) the continuous treatment for a condition (such as pregnancy) or (ii) duration of illness from the time of first contact with a healthcare provider through the point of release.

Contracted Provider – Providers that are licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency that have contracted with the MCO to provide health care services.

Core Benefits – A schedule of health care benefits provided to Medicaid MCO Members enrolled in the MCO's plan as specified under the terms of the Contract.

Covered Services – Services included in the South Carolina State Plan for Medical Assistance.

CPT – Current Procedural Terminology, most current edition.

DAODAS – South Carolina Department of Alcohol and Other Drug Abuse Services.

DHEC – South Carolina Department of Health and Environmental Control.

Direct Marketing – Any unsolicited personal contact with or solicitation of Medicaid Applicants/Eligibles in person, through direct mail advertising or teleMarketing by an employee or agent of the MCO for the purpose of influencing an individual to enroll with the MCO's Managed Care Plan.

Disease Management – Activities performed on behalf of the members with special health care needs to coordinate and monitor their treatment for specific identified chronic/complex conditions and diseases and to educate the member to maximize appropriate self-management.

Disenrollment – Action taken by SCDHHS, or its Enrollment broker, to remove a Medicaid MCO Member from the MCO's plan following receipt and approval of a written Disenrollment request.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – A Program mandated by Title XIX of the Social Security Act in support of routine medical visits for one of the following: EPSDT visit, family planning, follow-up to a previously treated condition or illness, and/or any other visit for other than the treatment of an illness. Services are limited to beneficiaries from birth to the month of their 21st birthday.

Eligible(s) – A person whom has been determined Eligible to receive services as provided for in the South Carolina State Plan for Medical Assistance under Title XIX.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

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

Encounter – any service provided to a Medicaid MCO Member regardless of how the service was reimbursed and regardless of provider type, practice specialty, or place of services. This would include expanded services/benefits as defined in the MCO contract.

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

Evidence of Coverage – The term which describes services and supplies provided to Medicaid MCO Members, which includes specific information on benefits, coverage limitations and services not covered. "Evidence of Coverage" may also be referred to as "Certificate of Coverage".

External Quality Review (EQR) – The analysis and evaluation by an EQRO of aggregated information on Quality, timeliness, and access to the health care services than an MCO or its contractors furnish to Medicaid MCO Members.

External Quality Review Organization (EQRO) – An organization that meets the competence and independence requirements set forth in 42 CFR§438.354, and performs External Quality Review, other EQR-related activities set forth in 42 CFR§438.358, or both.

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

Federally Qualified Health Center (FQHC) – A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants.

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

Grievance – A complaint, or expression of dissatisfaction about any matter other than an Action. The term is also used to refer to the overall system that includes Grievances and Appeals handled at the MCO level.

HCPCS – CMS’s Common Procedure Coding System.

Healthcare Medicaid Provider “Provider” – A provider of healthcare services or product which includes but is not limited to an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, or group or association approved by SCDHHS, licensed and/or credentialed which accepts payment in full for providing benefits to Medicaid MCO Member and is paid amounts pursuant to the MCO reimbursement provisions, business requirements and schedules.

Health Maintenance Organization (HMO) – A domestic licensed organization which provides or arranges for the provision of basic and supplemental health care services for members in the manner prescribed by the South Carolina State Department of Insurance and qualified by CMS.

Health Plan Employer Data and Information Set (HEDIS) – Standards for the measures set by the NCQA.

Health Insurance Protected Data Bank (HIPDB) – A national data collection Program for the reporting and disclosure of certain final adverse actions taken against health

care practitioners, providers and suppliers. It is required to be performed by the MCO, or its approved delegated credentialing entity, in the credentialing and recredentialing process outlined in this Policy and Procedure Guide and SCDHHS' contract requirement.

HHS – United States Department of Health and Human Services.

ICD – International Classification of Disease, Clinical Modification,

Incentive Arrangement – Any payment mechanism under which a MCO may receive additional funds over and above the capitation rates it was paid for meeting targets specified in the contract.

Inmate – A person who is housed in or confined to a correctional facility (e.g. prison, prison facility, jail etc.). This does not include individuals on probation or parole or who are participating in a community Program.

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

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

Managed Care Plan – The Program offered by the MCO related to benefits to Medicaid Member.

Marketing – Any communication approved by SCDHHS from an MCO to an existing or potential Medicaid Recipient that can be interpreted as intended to influence the Recipient to enroll in that particular MCO Medicaid product, or either to not enroll, or to disenroll from, another MCO Medicaid product.

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

Material Change – As applicable to contracts, a Material Change is one that is relevant and/or significant to the terms of the agreement as determined by one or both parties or SCDHHS.

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

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

Medicaid MCO Member – A Medicaid Eligible person(s) who is enrolled in an approved Medicaid MCO. For the purpose of this Policy & Procedure Manual and provider Subcontracts, a Medicaid MCO Member shall also include parents, guardians, or any other persons legally responsible for the member being served.

Medical Networks – An integrated delivery system of healthcare services, there can be multiple Medical Networks in a county.

Medical Record – A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, including, but not limited to, outpatient and emergency medical health care services whether provided by the MCO, its Subcontractor, or any out of plan providers.

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

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

MMIS – Medicaid Management Information System.

National Committee for Quality Assurance (NCQA) – a private, 501(c)(3) non-for-profit organization founded in 1990, dedicated to improve health care Quality.

National Practitioner Data Bank (NPDB) – A central repository for adverse action and medical malpractice payments which serves primarily as an alert or flagging system intended to facilitate a comprehensive review of a Health Care Provider's professional credentials.

NDC – National Drug Code.

Newborn – A live child born to a member.

Non-Contracted Provider – Providers that are licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency that have not contracted with or are not employed by the MCO to provide health care services.

Non-Covered Services – Services not covered under the South Carolina State Plan for Medical Assistance.

Non-Emergency – An Encounter with a Health Care Provider by a Medicaid MCO Member who has presentation of medical signs and symptoms, that do not require immediate medical attention.

Nurse Practitioner and Clinical Nurse Specialist – A registered nurse must complete an advanced formal education program and be licensed and certified by the Board of Nursing under the Department of Labor, Licensing and Regulations. Services are limited by practice protocol.

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

Physician's Assistant – A physician assistant is defined as a health professional that performs such tasks as approved by the State Board of Medical Examiners in a dependent relationship with a supervising physician or under direct personal supervision of the attending physician.

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

Post-Stabilization Services – Covered Services, related to an Emergency Medical Condition that are provided after a member is stabilized in order to maintain the stabilized condition, or improve or resolve the member's condition.

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

Primary Care Provider (PCP) – The provider who serves as the entry point into the health care system for the member. The PCP is responsible for including providing Primary Care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining Continuity of Care.

Prior Authorization – The act of authorizing specific designated services as outlined in the MCO's Policy and Procedure Guide (Provider Manual).

Program – The method of provision of Title XIX services to South Carolina Recipients as provided for in the South Carolina State Plan for Medical Assistance and SCDHHS regulations.

Protected Health Information (PHI) – means the same as the term protected health information in 45 CFR §160.103.

Quality – As related to External Quality Review, the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through structural and operational characteristics and through the provision of health services consistent with current professional knowledge.

Quality Assessment – Measurement and evaluation of success of care and services offered to individuals, groups or populations

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

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

Referral Services – Health care services provided to Medicaid MCO Members outside the MCO's designated facilities or its Subcontractors when ordered and approved by the MCO, including, but not limited to out-of-plan services which are covered under the Medicaid Program and reimbursed at the Fee-For-Service Medicaid rate.

Risk – A chance of loss assumed by the MCO which arises if the cost of providing Core Benefits and Covered Services to Medicaid MCO Members exceeds the Capitation Payment made by SCDHHS to the MCO under the terms of the contract.

Rural Health Clinic (RHC) – A South Carolina licensed rural health clinic is certified by the CMS and receiving Public Health Services grants.

Service Area – The geographic area in the state of South Carolina in which the MCO has been authorized by SCHHS for membership assignment and the provision of health care services to its membership.

SCDHHS – South Carolina Department of Health and Human Services

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

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

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

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

Subcontract – A written agreement between the MCO and a third party to perform a part of the MCO's obligations as specified under the terms of the Contract.

Subcontractor – Any organization, entity, or person who provides any functions or service for the MCO specifically related to securing or fulfilling the MCO's obligations to SCDHHS under the terms of the contract.

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

Targeted Case Management – Services which assist individuals in gaining access to needed medical, social, educational, and other services. Services include a systematic referral process to providers.

Third Party Liability (TPL) – Collection from other parties who may be liable for all or part of the cost of items or health care services provided to a Medicaid MCO Member.

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

UB-04 (or its successor) – A uniform billing format for inpatient and outpatient hospital billing.

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

Value Added Items and Services (VAIS) – Items and services provided to a Medicaid MCO Member that are not included in the Core Benefits and are not funded by Medicaid dollars. SCDHHS only allows “healthcare-related” VAIS. Healthcare-related VAIS are items or services that are intended to maintain or improve the health status of Medicaid MCO Members.

APPENDIX 1 — MEMBERS' AND POTENTIAL MEMBERS' BILL OF RIGHTS

Each Medicaid MCO Member is guaranteed the following rights:

1. To be treated with respect and with due consideration for his or her dignity and privacy.
2. To participate in decisions regarding his or her healthcare, including the right to refuse treatment.
3. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in the federal regulations on the use of restraints and seclusion.
4. To be able to request and receive a copy of his or her Medical Records, and request that they be amended or corrected.
5. To receive healthcare services that are accessible, are comparable in amount, duration and scope to those provided under Medicaid FFS and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
6. To receive services that are appropriate and are not denied or reduced solely because of diagnosis, type of illness, or medical condition.
7. To receive all information including but not limited to Enrollment notices, informational materials, instructional materials, available treatment options, and alternatives in a manner and format that may be easily understood.
8. To receive assistance from both SCDHHS and the MCO in understanding the requirements and benefits of the MCO's plan.
9. To receive oral interpretation services free of charge for all non-English languages, not just those identified as prevalent.
10. To be notified that oral interpretation is available and how to access those services.
11. As a potential member, to receive information about the basic features of managed care; which populations may or may not enroll in the program and the MCO's responsibilities for Coordination of Care in a timely manner in order to make an informed choice.
12. To receive information on the MCO's services, to include, but not limited to:
 - a) Benefits covered
 - b) Procedures for obtaining benefits, including any authorization requirements
 - c) Any cost sharing requirements
 - d) Service Area

- e) Names, locations, telephone numbers of and non-English language spoken by current contracted Providers, including at a minimum, primary care physicians, specialists, and hospitals.
 - f) Any restrictions on member's freedom of choice among network Providers.
 - g) Providers not accepting new patients.
 - h) Benefits not offered by the MCO but available to members and how to obtain those benefits, including how transportation is provided.
13. To receive a complete description of Disenrollment rights at least annually.
14. To receive notice of any significant changes in the Benefits Package at least thirty (30) days before the intended effective date of the change.
15. To receive information on the Grievance, Appeal and Fair Hearing procedures.
16. To receive detailed information on emergency and after-hours coverage, to include, but not limited to:
- a) What constitutes an Emergency Medical Condition, emergency services, and Post-Stabilization Services.
 - b) That Emergency Services do not require Prior Authorization.
 - c) The process and procedures for obtaining Emergency Services.
 - d) The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the contract.
 - e) Member's right to use any hospital or other setting for emergency care.
 - f) Post-Stabilization care Services rules as detailed in 42 CFR §422.113(c).
17. To receive the MCO's policy on referrals for specialty care and other benefits not provided by the member's PCP.
18. To have his or her privacy protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.
19. To exercise these rights without adversely affecting the way the MCO, its Providers or SCDHHS treat the members.

APPENDIX 2 — PROVIDERS' BILL OF RIGHTS

Each healthcare Provider who contracts with SCDHHS or subcontracts with the MCO to furnish services to the Medicaid Members shall be assured of the following rights:

1. A healthcare professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a Medicaid MCO Member who is his other patient, for the following:
 - a) The Medicaid MCO Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
 - b) Any information the Medicaid MCO Member needs in order to decide among all relevant treatment options
 - c) The risks, benefits, and consequences of treatment or non-treatment
 - d) The Medicaid MCO Member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions
2. To receive information on the Grievance, Appeal and Fair Hearing procedures.
3. To have access to the MCO's Policies and procedures covering the authorization of services.
4. To be notified of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
5. To challenge, on behalf of the Medicaid MCO Members, the denial of coverage of, or payment for, medical assistance.
6. The MCO's Provider selection Policies and procedures must not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.
7. To be free from discrimination for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification

APPENDIX 3 — TRANSPORTATION BROKER LISTING AND CONTACT INFORMATION

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

APPENDIX 4 — SUBCONTRACT BOILERPLATE REQUIREMENTS

The provisions in this Section shall be primary and supersede any provision to the contrary which may occur in any other section of this subcontract.

A. Definitions:

1. Action – As related to Grievance, either (1) the denial or limited authorization of a requested service, including the type or level of service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by SCDHHS; (5) the failure of the MCO to act within the timeframes provided in §9.7.1 of the MCO Contract; or (6) for a resident of a rural area with only one MCO, the denial of a Medicaid MCO Member's request to exercise his or her right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the MCO's network.
2. Additional Service(s) – A service(s) provided by the MCO which is a non-covered service(s) by the South Carolina State Plan for Medical Assistance and is offered to Medicaid MCO Members in accordance with the standards and other requirements set forth in the MCO Contract which are outlined in another section of this Contract.
3. Clean Claim – A claim that can be processed without obtaining additional information from the Provider of the service or from a third party.
4. Continuity of Care – The continuous treatment for a condition (such as pregnancy) or duration of illness from the time of first contact with a healthcare provider through the point of release or long-term maintenance.
5. Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy; serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
6. Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services under this title; and (2) needed to evaluate or stabilize an Emergency Medical Condition.
7. Federal Qualified Health Center (FQHC) – A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants. An FQHC provides a wide range of primary care and enhanced services in a medically under-served area.
8. Grievance – An expression of dissatisfaction about any matter other than an Action. The term is also used to refer to the overall system that

includes grievances and appeals handled at the MCO level. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid MCO Member's rights.)

9. Healthcare Medicaid Provider – A provider of healthcare services or products which includes but is not limited to an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, group or association approved by SCDHHS, licensed and/or credentialed which accepts as payment in full for providing benefits to Medicaid MCO Members amounts pursuant to the MCO reimbursement provisions, business requirements and schedules.
10. Managed Care Organization – An entity that has, or is seeking to qualify for, a comprehensive risk contract that is (1) a Federally qualified HMO that meets the advance directive requirements of subpart I of 42 CFR Part 489; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) makes the services it provides to its Medicaid MCO Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area serviced by the entity; and (b) meets the solvency standards of 42 CFR §438.116. This includes any of the entity's employees, affiliated providers, agents, or contractors.
11. Medically Necessary Service – Those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid MCO Member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of the Medicaid MCO Member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.
12. Medicaid MCO Member – An eligible person(s) who is enrolled with a SCDHHS approved Medicaid Managed Care Organization. For purpose of this subcontract, Medicaid MCO Member shall include the patient, parent(s), guardian, spouse or any other person legally responsible for the Medicaid MCO Member being served.
13. MCO - The Managed Care Organization who is requesting services under this Contract.
14. Primary Care Provider (PCP) – The provider who serves as the entry point into the health care system for the Medicaid MCO Member. The PCP is responsible for providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining Continuity of Care.
15. Rural Health Clinic (RHC) – A South Carolina licensed rural health clinic is certified by the Centers for Medicare and Medicaid Services and receiving Public Health Services grants. An RHC is eligible for state defined cost

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

16. Provider – The Healthcare Medicaid Provider who is providing services for the MCO under this Contract.

B. Administration

1. SCDHHS retains the right to review any and all subcontracts entered into for the provision of any services under this Contract.
2. SCDHHS does not require Provider to participate in any other line of business (i.e. Medicare Advantage or commercial) offered by the MCO in order to participate in the MCO's Medicaid network.
3. SCDHHS does not require Provider to participate in the network of any other Managed Care Organization as a condition of participation in MCO's network.
4. MCO and Provider shall be responsible for resolving any disputes that may arise between the two (2) parties, and no dispute shall disrupt or interfere with the Continuity of Care of a Medicaid MCO Member.
5. Provider represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. Provider further covenants that, in the performance of this Contract, no person having any such known interests shall be employed.
6. Provider recognizes that in the event of termination of the MCO Contract between MCO and SCDHHS, the MCO is required to make available to SCDHHS or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and Provider's activities undertaken pursuant to this Contract. The Provider agrees to furnish any records to the MCO which the MCO would need in order to comply with this provision. The provision of such records shall be at no expense to SCDHHS.
7. In the event of termination of this Contract, SCDHHS will be notified of the intent to terminate this Contract one hundred and twenty (120) calendar days prior to the effective date of termination. The date of termination will be at midnight on the last day of the month of termination.
8. If the termination of this Contract is as a result of a condition or situation which would have an adverse impact on the health and safety of Medicaid MCO Members, the termination shall be effective immediately and SCDHHS will be immediately notified of the termination and provided any information requested by SCDHHS.

C. Hold Harmless

1. At all times during the term of this Contract, Provider shall, except as otherwise prohibited or limited by law, indemnify and hold SCDHHS harmless from all claims, losses, or suits relating to activities undertaken pursuant to this Contract.
2. If Provider is not a political subdivision of the State of South Carolina, an affiliate organization, or otherwise prohibited or limited by law, Provider shall indemnify, defend, protect, and hold harmless SCDHHS and any of its officers, agents, and employees from:
 - a. Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the Provider in connection with the performance of this Contract;
 - b. Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by Provider, its agents, officers, employees, or subcontractors in the performance of this Contract;
 - c. Any claims for damages or losses resulting to any person or firm injured or damaged by Provider, its agents, officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by federal or state regulations or statutes;
 - d. Any failure of the Provider, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
 - e. Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of SCDHHS in connection with the defense of claims for such injuries, losses, claims, or damages specified above;
 - f. Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against SCDHHS or their agents, officers or employees, through the intentional conduct, negligence or omission of the Provider, its agents, officers, employees or subcontractors.
3. As required by the South Carolina Attorney General, in circumstances where the Provider is a political subdivision of the State of South Carolina, or an affiliate organization, except as otherwise prohibited by law, neither Provider nor SCDHHS shall be liable for any claims, demands, expenses, liabilities and losses (including reasonable attorney's fees) which may arise out of any acts or failures to act by the other party, its employees or agents, in connection with the performance of services pursuant to this Contract.

4. In accordance with the requirements of S.C. Code Ann. § 38-33-130(b) (Supp. 2001, as amended), and as a condition of participation as a Healthcare Medicaid Provider, Provider hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Medicaid MCO Members, or persons acting on their behalf, for health care services which are rendered to such Medicaid MCO Members by the Provider, and which are covered benefits under the Medicaid MCO Member's evidence of coverage. This provision applies to all covered health care services furnished to the Medicaid MCO Member for which SCDHHS does not pay the MCO or the MCO does not pay the Provider. Provider agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by MCO and insolvency of MCO. Provider further agrees that this provision shall be construed to be for the benefit of Medicaid MCO Members and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and such Medicaid MCO Members.
5. It is expressly agreed that the MCO, Provider and agents, officers, and employees of the MCO or Provider in the performance of this Contract shall act in an independent capacity and not as officers and employees of SCDHHS or the State of South Carolina. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the MCO or Provider and SCDHHS and the State of South Carolina.

D. Health Care Services

1. Provider shall ensure adequate access to the services provided under this Contract in accordance with the prevailing medical community standards.
2. The services covered by this Contract must be in accordance with the South Carolina State Plan for Medical Assistance under Title XIX of the Social Security Act, and Provider shall provide these services to Medicaid MCO Members through the last day that this Contract is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of SCDHHS or its designee.
3. Provider may not refuse to provide Medically Necessary Services or covered preventive services to Medicaid MCO Members for non-medical reasons.
4. Provider shall render Emergency Services without the requirement of prior authorization of any kind.
5. The Provider shall not be prohibited or otherwise restricted from advising a Medicaid MCO Member about the health status of the Medicaid MCO Member or medical care or treatment for the Medicaid MCO Member's condition or disease, regardless of whether benefits for such care or treatment are provided under the MCO Contract, if Provider is acting within the lawful scope of practice.

6. Provider must take adequate steps to ensure that Medicaid MCO Members with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended).
7. Provider shall provide effective Continuity of Care activities, if applicable, that seek to ensure that the appropriate personnel, including the Primary Care Provider (PCP), are kept informed of the Medicaid MCO Member's treatment needs, changes, progress or problems
8. Provider must adhere to the Quality Assessment Performance Improvement and Utilization Management (UM) requirements as outlined by SCDHHS and/or its designee.
9. Provider shall have an appointment system for Medically Necessary Services that is in accordance with prevailing medical community standards.
10. Provider shall not use discriminatory practices with regard to Medicaid MCO Members such as separate waiting rooms, separate appointment days, or preference to private pay patients.
11. Provider must identify Medicaid MCO Members in a manner which will not result in discrimination against the Medicaid MCO Member in order to provide or coordinate the provision of all core benefits and/or Additional Services and out of plan services.
12. Provider agrees that no person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of the MCO's program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of Provider. Provider shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination.
13. If the Provider performs laboratory services, the Provider must meet all applicable state and federal requirements related thereto.
14. If Provider is a hospital, Provider shall notify the MCO and SCDHHS of the births when the mother is a Medicaid MCO Member. Provider shall also complete SCDHHS Request for Medicaid ID Number (Form 1716 ME), including indicating whether the mother is a Medicaid MCO Member, and submit the form to the local/state SCDHHS office.
15. If Provider is an FQHC/RHC, Provider shall adhere to federal requirements for reimbursement for FQHC/RHC services. This Contract shall specify the agreed upon payment from the MCO to the FQHC/RHC. Any bonus or incentive arrangements made to the FQHCs/RHCs associated with Medicaid MCO Members must also be specified and included this Contract.

16. If Provider is a PCP, then Provider shall have an appointment system for covered core benefits and/or Additional Services that is in accordance with prevailing medical community standards but shall not exceed the following requirements:
 - a. Routine visits scheduled within four (4) to six (6) weeks.
 - b. Urgent, non-emergency visits within forty-eight (48) hours.
 - c. Emergent or emergency visits immediately upon presentation at a service delivery site.
 - d. Waiting times that do not exceed forty-five (45) minutes for a scheduled appointment of a routine nature.
 - e. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.
 - f. Walk-in patients with urgent needs should be seen within forty-eight (48) hours.
17. As a PCP, Provider must also provide twenty-four (24) hour coverage but may elect to provide twenty-four (24) hour coverage by direct access or through arrangement with a triage system. The triage system arrangement must be prior approved by MCO.
18. Provider shall submit all reports and clinical information required by the MCO, including Early Periodic Screening, Diagnosis, and Treatment (if applicable).

E. Laws

1. Provider shall recognize and abide by all state and federal laws, regulations and SCDHHS guidelines applicable to the provision of services under the Medicaid MCO Program.
2. Provider must comply with all applicable statutory and regulatory requirements of the Medicaid program and be eligible to participate in the Medicaid program.
3. This Contract shall be subject to and hereby incorporates by reference all applicable federal and state laws, regulations, policies, and revisions of such laws or regulations shall automatically be incorporated into the Contract as they become effective.
4. Provider represents and warrants that it has not been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or is not otherwise barred from participation in the Medicaid and/or Medicare program.
5. Provider also represents and warrants that it has not been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

6. Provider shall not have a Medicaid contract with SCDHHS that was terminated, suspended, denied, or not renewed as a result of any action of Center for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services (HHS), or the Medicaid Fraud Unit of the Office of the South Carolina Attorney General. Providers who have been sanctioned by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and are currently under suspension shall not be allowed to participate in the Medicaid MCO Program. In the event Provider is suspended, sanctioned or otherwise excluded during the term of this Contract, Provider shall immediately notify MCO in writing.
7. Provider ensures that it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other Contract with debarred individuals for the provision of items and services that are significant to the MCO's contractual obligation.
8. Provider shall check the Excluded Parties List Service administered by the General Services Administration, when it hires any employee or contracts with any subcontractor, to ensure that it does not employ individuals or use subcontractors who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other contract with debarred individuals for the provision of items and services that are significant to Provider's contractual obligation. Provider shall also report to the MCO any employees or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.
9. In accordance with 42 CFR §455.104 (2010, as amended), the Provider agrees to provide full and complete ownership and disclosure information with the execution of this Contract and to report any ownership changes within thirty-five (35) calendar days to MCO. Provider must download the appropriate form from the MCO website or request a printed copy be sent. Failure by the Provider to disclose this information may result in termination of this Contract.
10. It is mutually understood and agreed this Section of the Contract shall be governed by the laws and regulations of the State of South Carolina both as to interpretation and performance by Provider. Any action at law, suit in equity, or judicial proceeding for the enforcement of this Section of the Contract or any provision thereof shall be instituted only in the courts of the State of South Carolina. Specific provisions related to dispute resolution between the MCO and Provider related to the other sections of this Contract are provided in those other sections.

F. Billing a Medicaid MCO Member

Provider may only bill a Medicaid MCO Member under the following conditions:

1. When Provider renders services that are non-covered services and are

not Additional Services, as long as the Provider:

- Provides to the Medicaid MCO Member a written statement of the services prior to rendering said services, which must include:
 - The cost of each service(s)
 - An acknowledgement of Medicaid MCO Member's payment responsibility, and
 - Obtains Medicaid MCO Member's signature on the statement.
2. When the service provided has a co-payment, as allowed by the MCO, Provider may charge the Medicaid MCO Member only the amount of the allowed co-payment, which cannot exceed the co-payment amount allowed by SCDHHS.

G. Audit, Records and Oversight

1. Provider shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly accepted information elements for services rendered to Medicaid MCO Members pursuant to this Contract (including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed). Medicaid MCO Members and their representatives shall be given access to and can request copies of the Medicaid MCO Members' medical records, to the extent and in the manner provided by S.C. Code Ann. §44-115-10 et. seq., (Supp. 2000, as amended).
2. SCDHHS, HHS, CMS, the Office of Inspector General, the State Comptroller, the State Auditor's Office, and the South Carolina Attorney General's Office shall have the right to evaluate, through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Contract, including those pertaining to quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and Provider claims submitted to the MCO. The Provider shall cooperate with these evaluations and inspections. Provider will make office work space available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provision of services under this Contract.
3. Whether announced or unannounced, Provider shall participate and cooperate in any internal and external quality assessment review, utilization management, and Grievance procedures established by SCDHHS or its designee.
4. Provider shall comply with any plan of correction initiated by the MCO and/or required by SCDHHS.
5. All records originated or prepared in connection with the Provider's performance of its obligations under this Contract, including, but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the Provider in

accordance with the terms and conditions of this Contract. The Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Medicaid MCO Members relating to the delivery of care or service under this Contract, and as further required by SCDHHS, for a period of five (5) years from the expiration date of the Contract, including any Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five (5) year period, whichever is later. If Provider stores records on microfilm or microfiche, Provider must produce, at its expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request.

6. SCDHHS and/or any designee will also have the right to:
 - a. Inspect and evaluate the qualifications and certification or licensure of Provider;
 - b. Evaluate, through inspection of Provider's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to Medicaid MCO Members;
 - c. Audit and inspect any of Provider's records that pertain to health care or other services performed under this Contract, determine amounts payable under this Contract;
 - d. Audit and verify the sources of encounter data and any other information furnished by Provider or MCO in response to reporting requirements of this Contract or the MCO Contract, including data and information furnished by subcontractors.
7. Provider shall release medical records of Medicaid MCO Members, as may be authorized by the Medicaid MCO Member or as may be directed by authorized personnel of SCDHHS, appropriate agencies of the State of South Carolina, or the United States Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Contract.
8. Provider shall maintain up-to-date medical records at the site where medical services are provided for each Medicaid MCO Member for whom services are provided under this Contract. Each Medicaid MCO Member's record must be legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. SCDHHS representatives or designees shall have immediate and complete access to all records pertaining to the health care services provided to the Medicaid MCO Member.

H. Safeguarding Information

1. Provider shall safeguard information about Medicaid MCO Members according to applicable state and federal laws and regulations.
2. Provider shall assure that all material and information, in particular information relating to Medicaid MCO Members, which is provided to or obtained by or through the Provider's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be protected as confidential information to the extent confidential treatment is protected under state and federal laws. Provider shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.
3. All information as to personal facts and circumstances concerning Medicaid MCO Members obtained by the Provider shall be treated as privileged communications, shall be held confidential, and shall not be divulged to third parties without the written consent of SCDHHS or the Medicaid MCO Member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Medicaid MCO Members shall be limited to purposes directly connected with the administration of this Contract.
4. All records originated or prepared in connection with Provider's performance of its obligations under this Contract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the Provider and its subcontractors in accordance with the terms and conditions of this Contract.

I. Payment Timeframes

1. The MCO shall pay ninety percent (90%) of all Clean Claims from practitioners, either in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt. The MCO shall pay ninety-nine percent (99%) of all Clean Claims from practitioners, either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt. The date of receipt is the date the MCO receives the claim, as indicated by its data stamp on the claim. The date of payment is the date of the check or other form of payment.
2. The MCO and Provider may, by mutual agreement, establish an alternative payment schedule to the one presented.
3. Provider shall accept payment made by the MCO as payment-in-full for covered services and Additional Services provided and shall not solicit or accept any surety or guarantee of payment from the Medicaid MCO Member, except a specifically allowed by Subsection F, Member Billing, of this Section.

Managed Care Organizations Policy and Procedure Guide

4. This Contract shall not contain any provision which provides incentives, monetary or otherwise, for the withholding of Medically Necessary Services.
5. Any incentive plans for providers shall be in compliance with 42 CFR Part 434 (2009, as amended), 42 CFR §417.479 (2008, as amended), 42 CFR §422.208 and 42 CFR §422.210 (2008, as amended).

APPENDIX 5 — INCENTIVES AND WITHHOLDS REQUIREMENTS (DRAFT)

The Department has budgeted for quality incentives programs that will not exceed one percent (1%) of the total Capitation Payments made to the Health Plans. The Health Plan designated incentives are those incentives paid to the Health Plan by the Department to encourage specific activities and/or specified performance targets by their Providers.

The current Health Plan Contracts will cross two (2) state fiscal years (SFY). Year-1 SFY begins on July 1, 2012 and ends June 30, 2013. Year-2 SFY runs July 1, 2013 through December 31, 2013. For the incentives goals for Year-1, the Department has budgeted a total of \$16 million which is approximately one (1%) percent of the total \$1.67 billion budgeted for the Department of Care Management. Listed below are the incentives programs designated by the Department. These incentives will be paid to the Health Plan either on a quarterly or a semi-annually SFY by the Department.

Health Plan Quality Incentive Programs

Patient Centered Medical Home (PCMH)

The development of Patient Centered Medical Homes (PCMH) is defined through the certification process by the National Committee for Quality Assurance (NCQA) and accreditation is site specific.

The Department will make payments to the Health Plans on a quarterly basis as outlined in the Health Plan's Policy and Procedures (P&P) Guide. ..

The Health Plans are required to pay Providers that are currently in the application process or that have achieved NCQA accreditation, Level 1, 2 or 3. The Health Plans may not pay any less than the payments listed below.

- o Application Period: \$0.50 Provider/\$.10 Health Plan
- o Level I Certification: \$1.00 Provider/\$0.15 Health Plan
- o Level II Certification: \$1.50 Provider/\$0.20 Health Plan
- o Level III Certification: \$2.00 Provider/\$0.25 Health Plan

Birth Outcomes Quality Initiatives (BOI)

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT):**
 - o In an effort to improve health outcomes for mothers and infants, the goal is to screen every pregnant Health Plan Medicaid Member for smoking, alcohol, substance use, depression and domestic violence.
 - o The Department will make payments of \$20 to the Health Plan on a quarterly basis for completion of the screening tool submitted by the Health Plan's Provider.

- **Centering Program:**
 - The goal is to adopt a program wherein the Health Plan's pregnant Medicaid Members meet with a group of peers to discuss their healthy approaches to eating, exercise and to provide peer support.
 - The Department will pay the Health Plan on a quarterly basis for each of its Medicaid Members who have attended at least five (5) or more of the peer group sessions with the certified centering provider. A certified centering provider is a provider who has been certified by the Centering Healthcare Institute. The Department will pay the Health Plan \$200 for each qualified Medicaid Member. The Health Plan may retain \$50 and shall pay the certified Provider the remaining balance of \$150.

- **Nurse Family Partnership:**
 - The goal is to improve the health, education, and economic self-sufficiency of the Health Plan's pregnant Medicaid Member. The Department will make quarterly payments of \$250 to the Health Plan a maximum total of \$2,000 for eight (8) quarters.

- **Decrease in Premature or Low Birth Weight (LBW) babies:**
 - Prematurity is defined as any birth prior to 37 weeks
 - Low birth weight babies are defined as any birth of less than 5.5 lbs.
 - The Department will pay the Health Plan \$100,000 on a semi-annual basis for meeting the targeted reduction in either the Health Plan's Low Birth Rate (LBW) or a decrease in its prematurity rate. An aggregate score will be calculated reflecting a 2.5% reduction for a six (6) month time frame, and an annual rate of 5% reduction in prematurity or LBW infant rates for the Health Plan. The Department, or its designee, will evaluate the Health Plan's performance through its encounter data, and as verified by the SCDHEC Birth Record links to FY 2011 Medicaid data.

Required Documentation for Quality Incentive Payment

Health Plans must submit quarterly documentation within the timeframe as outlined in the reporting requirements sections of the Health Plan P&P guides. The Health Plan must report the information in the format as outlined in the Reports Companion Guide. The cutoff date for each SFY quarter will be the last Friday of the third month of the SFY quarter. The Reports Companion Guide can be found at <http://www.scdhhs.gov/Internet/pdf/HEALTHPLAN%20Reports%20Companion%20Guide%20June%202011.pdf>. Documentation will be verified by The Department or its designee. Care Management program staff will calculate the appropriate credit/debit adjustments due to/from the Health Plan. If there are material changes, as determined by The Department, to the quality payments during the SFY incentive period, the Department reserves the right to adjust the payments accordingly. As in all cases the Department makes the final decision.

Patient Centered Medical Home

Application Process Requirements

- Initially the Health Plan must complete and submit the information in the format as outlined in the Reports Companion Guide with a copy of the NCQA Application Letter and a defined timeline for the Provider to achieve accreditation. After the initial submission the Health Plan is not required to continue to submit the documentation again until the eighteen month. However with each quarterly submission the Health Plan must include an attestation that the Provider is still seeking NCQA accreditation. If the Provider has not achieved NCQA accredited within eighteen (18) months the Health Plan must provide a detailed description outlining the reasons why the Provider has not achieved NCQA accreditation. SCDHHS, at its discretion, will determine if the documentation submitted by the Health Plan justifies the incentive payments already made to the Health Plan. If the Department determines it does not the Department may recover the total amount of incentives paid to the Health Plan through a gross level adjustment.

Site Accredited by NCQA PCMH Required Documentation

- Initially the Health Plan must complete and submit the information in the format as outlined in the Reports Companion Guide with a copy of the accreditation documentation awarded to the Provider's site. If the Provider achieves the next level of accreditation (i.e. application to Level I or to Level II etc.) the Health Plan will receive the increased incentive as outlined, in the month Provider accreditation was achieved. The Health Plan must increase the incentive payment to the Provider in the month the accreditation was achieved as outlined above.
- The Health Plan must include an attestation with each quarterly report submission verifying the status (Level I, Level II, Level III) of all Providers site locations that continue to be accredited at the NCQA PCMH level. Additionally, the Health Plan must indicate the total number of its Medicaid Members assigned to each qualifying Provider's accredited site locations. The cutoff date for the submission will be the last Friday of the third month of the SFY quarter.

Birth Outcomes Quality Initiatives Documentation

Health Plans must submit quarterly documentations in accordance with the policies as outlined in the reporting requirements in the Health Plans' P&P guide and in the format as outlined in the Reports Companion Guide. Documentation will be verified by The Department or its designee. If there are material changes, as determined by SCDHHS, to the incentive payments made during the SFY incentive period the Care Management staff will calculate the appropriate credit/debit adjustments due to the Health Plan, The Department reserves the right to adjust the payments accordingly. As in all cases of interpretation, the Department has the final decision.

- **Screening, Brief Intervention, and Referral to Treatment (SBIRT):**
 - The Health Plan is not required to submit any documentation to the Department for this calculation. The Department, or its designee, will calculate the amount due to the Health Plan by calculating the number of times the code H0002, with

modifier, is found in the Health Plan's encounter data. This code may be utilized only once by the Health Plan's Medicaid Member in a rolling 12 month period.

- **Centering Program:**
 - Initially the Health Plan must complete and submit the documentation for Centering Programs as outlined in the Health Plan's P&P Guide and Reports Companion Guide. In addition to the reporting information the Health Plan must include a copy of the certificate from the Centering Healthcare Institute with the initial submission. Each SFY quarter the Health Plan must submit copies of sign-in logs reflecting their members who have completed at least five (5) or more visits to the Centering Program. The Health Plan's Medicaid Member cannot be submitted more than once in a single pregnancy.

- **Nurse Family Partnership:**
 - Initially the Health Plan must complete and submit the documentation as outlined in the Health Plan's P&P Guide and Reports Companion Guide. Each quarter the Health Plan will submit a list of the total number of its Medicaid Members who have received services from the Nurse Family Partnership Provider. The Department, or its designee, will validate the submission and will issue payment in the form of a gross level adjustment to the Health Plan.

- **Decrease In Premature and Low Birth Weight(LBW)¹ babies:**
 - Baseline data from the CHAMPIONS BOI report for each hospital will be associated with Medicaid beneficiaries enrolled in a Health Plan and compared quarterly with changes in the number of premature and low birth weight children. The baseline for this quality incentive will use data from claims/encounters in FY 2011 to establish an aggregate rate per 1,000 members enrolled in the plan. The Department or its designee will evaluate the Health Plan performance through its claims/encounter data and as verified by the SCDHEC Birth Record links to FY 2011 Medicaid data. The Health Plan will not have to submit any data for reporting purposes. An aggregate score will be calculated reflecting a six (6), month and an annual rate. It is anticipated that the calculations will be determined within 90 days of the completion of each 6 month cycle and payment will be made to the MCOs within 30 days of completion of the calculations.

Process for Recovery of Incentive Payments

The Department reserves the right not to make incentive payments to a Health Plan if it fails to submit timely and accurate reports as outlined in the Health Plan's P&P Guide and in the format as outlined in the Reports Companion Guide. If the Department discovers the Health Plan has submitted information that is not accurate, (i.e. provider accreditation was not achieved; or accreditation levels were not accurate; or the Provider has lost accreditation and should not have received incentives payments), The Department, at its discretion, may recover the total amount of incentive payments to the Health Plan, and may also include liquid damages as outlined in Section 13 of the Health Plan's Contract.

¹ **Low-birth-weight infant** – is an infant born weighing less than 5.5 pounds (2500 grams). While the very low birth weight infant weigh less than 3 pounds, 5 ounces (1500 grams) at birth.

Withhold for Quality Performance Measures

The Department has established at-risk performance-based quality measures. These at-risk performance measures are based on a calendar year. Year-1 is defined as July 1, 2012 through December 31, 2012.

For Year-1 performance measures the Department has implemented an annualized withhold of 1.0% which will be applied retrospectively to the Health Plans. Health Plans will identify nine (9) quality measures they wish to target for improvement in CY 2012. The Department will identify one mandatory quality measure to target for improvement. The Department or its designee will provide each participating Health Plan with the benchmark and corresponding incremental improvement goal for each measure. The Health Plan will report on all measures using administrative data. For Year-1 performance measures, data from CY 2011 will serve as the benchmark for each measure. The Department or its designee will establish the corresponding incremental improvement target for each measure, which will be Health Plan-specific. The Department or its designee will then measure the change from CY 2011 as compared to CY 2012 performance measures. Improvement is defined as one standard deviation from the mean.

If the Health Plan has two (2) or more of the ten (10) measurements that fall below the 25th percentile, the Health Plan will not qualify for return of any of the withhold amount. However, if the Health Plan has three (3) or more of the ten (10) measurements above the 75th percentile, the Health Plan may qualify for participation in a bonus pool subject to availability of funds. To receive return of withhold in a category of measurement, the Health Plan must improve one standard deviation in the measurements between CY 2011 and CY 2012. One standard deviation and improvement will be determined by The Department or its designee.

The Department or its designee will provide the Health Plan with quarterly updates of their performance related to their ten (10) measurements. It is anticipated that data for Year 1 performance and determination of the measures will be in the fall of 2013.

If it is determined that the Health Plan did not meet the standards as outlined above the Department will deduct the amount of the withhold retrospectively based on the capitated payments to the Health Plan from July 1, 2012 through December 31, 2012. This will be done by a gross level adjustment. If the Department determines that the Health Plan has met all required performance targets, the Health Plan will not be assessed the retroactive withhold.

Year-2

Year-2 is defined as January 1, 2013 until December 31, 2013. The at-risk performance measures will increase to sixteen (16). In addition, withholds will increase to 1.5% and will be applied prospectively to the monthly capitated rate paid to the Health Plans by gross level adjustments.

Disposition of Undistributed Withhold Funds

The goal is to return all the withhold funds to the Health Plans in both Year-1 and 2. In the event the withhold pool is not fully distributed to the Health Plans, the Department will return all federal matched funds as required by CMS, and the remaining balance of the state funds may, at the

Department's discretion, either be maintained in the pool or distributed in support of other health quality initiatives.

APPENDIX 6 — QUALITY WEIGHTED AUTO ASSIGNMENTS

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.

SCDHHS will be implementing a Quality Weighted Assignment algorithm for enrollments that begin on January 1, 2013. Beneficiaries that are managed care assignable but have not selected a health plan will be assigned to a health plan by the enrollment broker based on this algorithm.

Assignments will be applied in the following order:

1. Newborns (defined as beneficiaries under the age of twelve months linked to a Medicaid eligible mother) are not included in the Quality Weighted Assignment algorithm. These beneficiaries are assigned in a separate process on a daily basis.
2. All other beneficiaries that are assignable will be included in the Quality Weighted Assignment algorithm as described below. Families with multiple members in an assignment pool will be assigned to the same health plan.

The Quality Weighted Assignment algorithm is linked to a health plan's Overall Score on the Health Plan Report Card. The Report Card will be updated twice annually, in July and January. The first assignments utilizing Quality will occur based on the scores from calendar year 2011 and released in September 2012. Thereafter, the ratings that are updated in July will be applied beginning in January and the ratings that are updated in January will be applied in July. The algorithm is as follows:

Health Plan Rating on Report Card	Quality Weighted Assignment Factor
5 Stars (90 th percentile or above)	2.5
4 Stars (75 th – 89 th percentile)	2.5
3 Stars (50 th – 74 th percentile)	1.5
2 Stars (25 th – 49 th percentile)	1.0
1 Star (below 25 th percentile)	0

The Quality Weighted Assignment Factors listed above represent the assignment factors associated with each Health Plan Rating on the report card. A two star rated plan will receive one member; a three star rated will receive 1.5 members for each member that a 2 star receives; a four and five star rated plan will receive 2.5 members for each member that a 2 star receives.

The following definitions will apply to health plans:

1. Existing health plan: An existing health plan is one that has a health plan rating within the last eighteen (18) months. Existing health plans will receive member assignments based on the Quality Weighted Assignment Factor on the latest Report Card.
2. New health plan: A new health plan is one that has not had a health plan rating within the last eighteen (18) months. New health plans will receive member assignments for twelve months (coinciding with the start of a new semi-annual period in July or January) based on the Quality Weighted Assignment Factor for a three (3) Star plan. After the initial starting period, assignments will be based on the actual star value for the health plan as indicated by the Report Card.
3. Merger or the acquisition of health plans: In the event of a merger between health plans, the member assignments algorithm will be based on the average Quality Weighted Assignment Factor for all health plans included in the merger. If the health plan is acquired by another health plan (domestic or foreign as defined by SCDOI) the acquiring health plan assumes the star rating of the health plan it acquired. If any health plan does not have a rating at the time of the merger, a three (3) star rating will be assumed until a rating is available for the newly merged health plan. Mergers will be coordinated to occur in July or January, coinciding with the release of the semi-annual Quality Weighted Assignment Factors.

Special considerations will apply to any health plan that was operating under a corrective action plan (CAP) during the previous period or at the start of a current period. Member assignments for health plans that were or are operating under a CAP will be based on the star rating that is one less than the rating at the time of the CAP. This special consideration will continue for the next full rating period (six months) after the removal of the CAP.

When applying the Quality Weighted Assignment algorithm, the enrollment broker must apply the formula on a county by county basis, as each health plan is not present in every county.

Example of Assignment Logic:

The assignment logic needs the following data elements in order to work properly:

1. Number of assignable members
2. Count of Health Plans at each star level
3. Formula to be applied per county

The formula is as follows:

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

Variables:

Assignable members in county: 1000

Plans @ 2 stars: 5

Plans @ 3 stars: 1

Plans @ 4 stars: 0

Plans @ 5 stars: 0

Value of 1 star:

$$((1000)/(5*2)+(1*3)+(0*4)+(0*5)) = 1000/10+3+0+0 = 1000/13 = 77$$

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

2 star plans get $2*77 = 154$ each plan * 5 plans = 770

3 star plans get $3*77 = 231$ each plan * 1 plan = 231

Total Assigned = $770 + 231 = 1001$ (rounded down to 1000)