

CONTRACT

BETWEEN

SOUTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

«providercaps»

FOR THE PURCHASE AND PROVISION OF MEDICAL SERVICES

UNDER THE SOUTH CAROLINA MEDICAID MCO PROGRAM

DATED AS OF

July 1, 2012

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CONTRACT BETWEEN SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES AND STANDARD MCO CONTRACTOR FOR THE PURCHASE AND PROVISION OF MEDICAL SERVICES UNDER THE SOUTH CAROLINA MEDICAID MCO PROGRAM DATED AS OF July 1, 2012.

This Contract is entered into as of the first day of July 2012 by and between the South Carolina Department of Health and Human Services, Post Office Box 8206, 1801 Main Street, Columbia, South Carolina, 29202-8206, hereinafter referred to as "Department" and «provideraddress» hereinafter referred to as "Contractor".

RECITALS

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

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

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

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

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

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

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

1 GENERAL PROVISIONS

1.1 Effective Date and Term

This Contract and its appendices, hereby incorporated, contain all of the terms and conditions agreed upon by the parties. All terms and conditions stated herein are subject to prior approval by CMS. To ensure the availability of Federal Financial Participation (FFP) for the entire contract period, this Contract must be submitted to CMS for prior approval at least forty-five (45) calendar days in advance of the proposed effective date. This Contract shall be effective no earlier than the date it has been approved by CMS, and signed by the Contractor and the Department, and shall continue in full force and effect from July 1, 2012 until December 31, 2013 unless terminated prior to that date by provisions of this Contract. The documents referenced in this Contract are on file with the Contractor and with the Department, and the Contractor is aware of their content.

1.2 Notices

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

In case of notice to Contractor:

«provider»
«Address1»
«citystatezip»

In case of notice to the Department:

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

cc: Chief, Bureau of Care Management and Medical Support
Services
Chief, Bureau of Administrative Services

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

1.3 Definitions

The definitions and contractual terms used in this Contract shall be construed and/or interpreted by the Department including the definitions set forth in Appendix A. In case of a dispute between the Contractor and the Department, the Contractor acknowledges and agrees that the Department's interpretation shall rule.

1.4 Entire Agreement

The Contractor shall comply with all the provisions of the Contract, including amendments and appendices, and shall act in good faith in the performance of the provisions of said Contract. The Contractor shall be bound by Medicaid policy as stated in applicable provider manuals and in the Managed Care Organization Policy and Procedure Guide. The Contractor agrees that failure to comply with the provisions of this Contract may result in the assessment of liquidated damages, sanctions and/or termination of the Contract in whole or in part, as set forth in this Contract. The Contractor shall comply with all applicable Department policies and procedures in effect throughout the duration of this Contract period. The Contractor shall comply with all Department handbooks, bulletins and manuals relating to the provision of services under this Contract. Where the provisions of the Contract differ from the requirements set forth in the handbooks and/or manuals, then the Contract provisions shall control.

The Department, at its discretion, will issue Medicaid bulletins to inform the Contractor of changes in policies and procedures which may affect this Contract. The Department is the only party to this Contract which may issue Medicaid bulletins.

1.5 Federal Approval of Contract

The CMS Regional Office shall review and approve all MCO contracts, including those risk and non-risk contracts that, on the basis of their value, are not subject to the prior approval requirements in 42 CFR §438.806. The CMS has final authority to approve this comprehensive risk based contract between the Department and the Contractor in which payment hereunder shall exceed One Hundred Thousand Dollars (\$100,000.00). If CMS does not approve this Contract, then the Contract will be considered null and void.

1.6 Extension & Renegotiation

This Contract may be extended for a period which may be less than but not exceed one (1) year beyond the initial contract term whenever either of the parties hereto provide the other party with ninety (90) calendar days advance notice of intent to extend and written agreement to extend the Contract is obtained from both parties. Any rate adjustment(s) shall be set forth in writing and signed by both parties. Either party may decline to extend this Contract for any reason. The parties expressly agree there is no property right in this Contract. This contract may be renegotiated for good cause, only at the end of the contract period, and for modification(s)

during the contract period, if circumstances warrant, at the discretion of the State.

1.7 Amendments

This Contract may be amended at any time as provided in this paragraph. This Contract may be amended whenever required to comply with state and federal requirements. No modification or change of any provision of the Contract shall be made or construed to have been made unless such modification is mutually agreed to in writing by the Contractor and SCDHHS, and incorporated as a written amendment to this Contract prior to the effective date of such modification or change. Any amendment to this Contract shall require prior approval by the Department, CMS, and the CMS Regional Office prior to its implementation.

1.8 Moral or Religious Objections to Providing Certain Covered Services

Pursuant to federal law, health care providers may choose not to provide certain medical services (i.e. abortion, sterilization, and family planning) due to moral or religious objections. If the Contractor chooses not to provide its members with these medical services, which are Covered Services under the South Carolina Medicaid program, the Department will provide the Contractor's Medicaid MCO Members with these services as specified in the South Carolina State Plan for Medical Assistance. The Contractor's Capitation Payment amounts will be adjusted to account for the services not provided by the Contractor. In this situation only, the Contractor is exempt from certain contract requirements, such as providing reports associated with these services. Any exemptions from contract requirements will be specifically identified in the MCO Policy and Procedure Guide.

2 **FINANCIAL MANAGEMENT**

The Contractor shall be responsible for sound fiscal management of the health care plan developed under this Contract. The Contractor shall adhere to the minimum guidelines outlined below.

2.1 Capitation Payments

The Contractor agrees to accept the Capitation Payments remitted by the Department to the Contractor as payment in full for all services provided to Medicaid MCO Members pursuant to this Contract. The Capitation Payment is equal to the monthly number of Medicaid MCO Members in each category multiplied by the capitation rate established for each category per month plus a maternity kicker payment for each Medicaid MCO Member who delivers during the month. To the extent there are material changes, as determined by the Department, to the Medicare fee schedule and subsequent changes to the Medicaid fee schedule during the Contract period, the Department reserves the right to adjust the capitation rates accordingly.

2.1.1 No more frequently than once during each State Fiscal Year, the Department reserves the right to defer remittance of the Capitation Payment to the Contractor. The Department will notify Contractor

of such deference at least fourteen (14) business days prior to the expected payment date. The Department may defer the Capitation Payment for a period not longer than thirty-three (33) calendar days from the original payment date to comply with the Department's fiscal policies and procedures.

2.1.2 In the event the federal government lifts any moratorium on supplemental payments to physicians or facilities, capitation rates in this Contract will be adjusted accordingly.

2.2 Payment to Federally-Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

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

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

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

2.2.4 The Contractor shall submit the name of each FQHC/RHC and detailed Medicaid encounter data (i.e. Medicaid recipient data, payment data, service/CPT codes) paid to each FQHC/RHC by month of service to the Department for State Plan required reconciliation purposes. This information shall be submitted in the format required by the Department as contained in the MCO Policy and Procedure Guide and must be no less accurate than ninety-seven (97%) upon receipt by the Department.

2.3 Co-payments

Co-payments for Adult Medicaid MCO Members aged 19 and older will be allowed under this Contract. Any cost sharing imposed on Medicaid MCO Members must be in accordance with 42 CFR §§447.50 -447.58.

2.4 Ancillary Services Provided as a Hospital Inpatient

Ancillary services which are provided in the hospital include, but are not limited to, radiology, pathology, emergency medicine and anesthesiology. When the Contractor's Medicaid MCO Member is provided these services as an inpatient, the Contractor 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 inpatient services shall not be required of either network or non-participating Providers.

2.5 Return of Funds

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

In addition, the Contractor shall reimburse the Department for any federal disallowances or sanctions imposed on the Department as a result of the Contractor's failure to abide by the terms of the Contract. The Contractor will be subject to any additional conditions or restrictions placed on the Department by HHS as a result of the disallowance. Payments of funds being returned to the Department shall be submitted to:

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

2.6 Third Party Liability (TPL)

Medicaid is the payer of last resort and pays after any other sources of payment for Covered Services. Federal law requires South Carolina to have in place processes and procedures to identify third parties liable for payment of services under the South Carolina State Plan for Medical Assistance and for payment of claims involving third parties. See S.C. Code Ann. § 43-7-410 et seq (Supp. 2011, as amended) for definitions and statutory requirements. Federal law considers the program outlined in the South Carolina statute and the federal regulations to be the Third Party Liability (TPL) program. It involves identification of other payers, including, but not limited to, group health and other health insurers, liability insurance and workers' compensation insurance.

In accordance with federal law, South Carolina state law considers all Medicaid Recipients to have assigned their rights to payment or recovery from a third party or private insurer to the Department. State law also requires that Medicaid Recipients cooperate with the Department in the enforcement of these assigned rights. Failure to cooperate with the Department violates the conditions for eligibility and may result in the loss of Medicaid eligibility on the part of the Recipient. South Carolina law also subrogates the Department to the Medicaid Recipient's right to recover from a third party.

Under this Contract, the Department is delegating to the Contractor the responsibility for administering the TPL program requirements in accordance with state and federal as they apply to services provided under this Contract to Medicaid MCO Members.

The Contractor shall report all third party recoveries for its Medicaid MCO Members to the Department in the format specified in the MCO Policy and Procedure Guide. For any third party recoveries collected after the reporting period for encounter data, the Contractor shall report this information to the Department in the same format as specified in the MCO Policy and Procedure Guide. See the MCO Policy and Procedure Guide, Third Party Liability.

- 2.6.1 The Department will share data with the Contractor regarding any third party insurance coverage it identifies for any covered Medicaid MCO Member. While the Department will make reasonable efforts to ensure that the shared data is accurate, the Department cannot guarantee the accuracy of the data. (See the MCO Policy and Procedure Guide)
- 2.6.2 The Contractor is required to identify any third party insurance coverage for their Medicaid MCO Member of which the Contractor has notice. The Contractor shall also inform the Department of any change or lapse in the Medicaid MCO Member's third party insurance coverage of which the Contractor has notice. The Contractor shall inform the Department of new coverage or any changes to existing coverage in the monthly submissions subsequent to the month in which the Contractor learns of the coverage or change to the coverage. The monthly submission must be provided in the required format as outlined in the MCO Policy and Procedure Guide, Third Party Liability.
- 2.6.3 If after the Contractor makes all reasonable efforts to obtain Medicaid MCO Member cooperation, a Medicaid MCO Member refuses to cooperate with the Contractor in pursuit of liable third parties, the Contractor will consult with the Department.

2.7 Provider-Preventable Conditions

The Contractor must comply with the federal requirements mandating provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR 434.6(a)12 (2011, as amended) and 42 CFR 447.26 (2011, as amended).

- 2.7.1 No payment will be made by the Contractor to a provider for provider-preventable conditions, as identified in the State Plan.
- 2.7.2 The Contractor will require that all providers agree to comply with the reporting requirements in 42 CFR 447.26(d) as a condition of payment from the Contractor.
- 2.7.3 The Contractor will comply with such reporting requirements to the extent the contractor directly furnishes services.

2.8 Fidelity Bonds

The Contractor shall secure and maintain during the life of this Contract a blanket fidelity bond from a company doing business in the State of South Carolina on all personnel in its employment. The bond shall be issued in accordance with South Carolina Department of Insurance (SCDOI) requirements, per occurrence. Said bond shall protect the Department from any losses sustained through any fraudulent or dishonest act or acts committed by any employees, agents, assigns, independent contractors and anyone else acting on behalf of the Contractor and subcontractors.

2.9 Stop Loss

The Contractor shall participate in a stop loss protection program in accordance with S.C. Code Ann. §38-33-130 (Supp. 2000, as amended). The Contractor shall submit a copy of the third party reinsurance contract, to SCDOI prior to its execution of this Contract and initial Medicaid enrollment.

2.10 Protection Against Insolvency

The Contractor shall establish an insolvency protection account as required by the SCDOI and federal law. The Contractor shall provide continuing proof of solvency, in accordance with S.C. Code Ann. § 38-33-130 (Supp. 2000, as amended) and 25A S.C. Code Ann. Regs. §69-22 (Supp. 2000, as amended). The Contractor shall submit proof of insolvency protection account approved by SCDOI prior to execution of this Contract and initial Medicaid MCO Member enrollment.

2.11 Surplus Start Up Account

The Contractor shall maintain the required amount of working capital pursuant to S.C. Code Ann. §38-33-100, (Supp. 2000, as amended), and 25A S.C. Code Ann. Regs. §69-22 (Supp. 2000, as amended), as amended and approved by SCDOI.

2.12 Surplus Account Reserves

The Contractor shall maintain at all times surplus account reserves as required by the SCDOI and state law. In the event that the Contractor's surplus falls below any applicable statutory requirements, the Department shall prohibit the Contractor from engaging in enrollment activities, shall cease to process new enrollments and shall not renew this Contract until the required balance is achieved, and certified by the SCDOI.

2.13 Insurance

The Contractor shall maintain, throughout the performance of its obligations under this Contract, a policy or policies of worker's compensation insurance with such limits as may be required by law, and a policy or policies of general liability insurance insuring against liability for injury to, and death of, persons and damage to, and destruction of, property arising out of or based upon any act or omission of the Contractor or any of its Subcontractors or their respective officers, directors,

employees or agents. Such general liability insurance shall have limits sufficient to cover any loss or potential loss resulting from this Contract.

It shall be the responsibility of the Contractor to require any Subcontractor to secure the same insurance as prescribed herein for the Contractor. In addition, the Contractor shall indemnify and hold harmless the Department from any liability arising out of the Contractor's untimely failure in securing adequate insurance coverage as prescribed herein. All such coverages shall remain in full force and effect during the initial term of the Contract and any renewal thereof.

2.14 Proof of Insurance

At any time, upon the request of the Department or its designee, the Contractor shall provide proof of insurance required in this Contract and the Contractor shall be the named insured on the insurance policy or policies.

2.15 Reinsurance

The Contractor shall hold a certificate of authority and file all contracts of reinsurance, or a summary of the plan of self-insurance. All reinsurance agreements or summaries of plans of self-insurance shall be filed with the SCDOI as required in S.C. Code Ann. §38-33-30 (D), (Supp. 2000, as amended) and any modifications thereto must be filed and approved by the SCDOI. Reinsurance agreements shall remain in full force and effect for at least thirty (30) calendar days following written notice by registered mail of cancellation by either party to the director of the SCDOI or his designee. The Contractor's reinsurance agreements shall remain in force throughout the Contract period, including any extension(s) or renewal(s).

2.16 Contractor Accreditation

Contractor must require any Subcontractor to provide proof of accreditation annually. If the Subcontractor changes or intends to change its accreditation body the Subcontractor must notify the Contractor within five (5) business days after the new accreditation has been achieved.

2.17 Errors and Omissions Insurance

The Contractor shall obtain, pay for, and keep in force for the duration of the Contract Errors and Omissions insurance, in the amount of at least One Million Dollars (\$1,000,000.00), per occurrence.

3 CONTRACTOR'S HEALTH PLAN ADMINISTRATION AND MANAGEMENT

3.1 Health Plan Administration and Management

The Contractor shall be responsible for the administration and management of its responsibilities under this Contract and the health plan covered thereunder, including all subcontractors, employees, agents, and anyone acting for or on behalf of the Contractor.

No subcontract or delegation of responsibility shall terminate the legal responsibility of the Contractor to SCDHHS to assure that all requirements under this Contract are carried out.

3.1.1 Staff Requirements

The staffing for the health plan covered under this Contract must be capable of fulfilling the requirements of this Contract, in accordance with the MCO Policy and Procedure Guide. The minimum staffing requirements are as follows:

- 3.1.1.1 A full-time administrator (project director) specifically identified to administer the day-to-day business activities of the Contract;
- 3.1.1.2 Sufficient full-time support staff as determined by SCDHHS, qualified by training and experience to conduct daily business in an orderly manner, including but not limited to such functions as marketing, Grievance system resolution, maintenance of a medical record system, enrollment/disenrollment and claims processing and reporting, as deemed appropriate, and determined through management and medical reviews;
- 3.1.1.3 A physician licensed in the State of South Carolina to serve as medical director to oversee and be responsible for the proper provision of covered services to Medicaid MCO Program members under this Contract. The medical director must have substantial involvement in the Quality Assessment activities.
- 3.1.1.4 Staff trained and experienced in data processing and data reporting as required to provide necessary and timely reports to SCDHHS;
- 3.1.1.5 Sufficient support staff (clerical and professional) to process grievances within the required time frames, and to assist complainants in properly filing grievances;
- 3.1.1.6 Sufficient staff qualified by training and experience to be responsible for the operation and success of the Quality Assessment and Performance Improvement program (QAPI). The QAPI staff shall be accountable for quality outcomes in all of the Contractor's own network providers, as well as subcontracted providers, as stated in 42 CFR §§438.200 – 438.242 and;
- 3.1.1.7 A designated compliance officer and a compliance committee that are accountable to senior management. The compliance officer will have effective lines of communication with all the Contractor's employees. (See monitoring and reporting requirements within the MCO Policy and Procedure Guide and 42 CFR §438.608)

3.1.2 Licensure of Staff

All of the Contractor's network Providers must be licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency, as applicable. All of the Contractor's network Providers/Subcontractors must comply with all applicable statutory and regulatory requirements of the Medicaid program and be eligible to participate in the Medicaid program.

The Contractor shall be responsible for assuring that all persons, whether employees, agents, Subcontractors or anyone acting for or on behalf of the Contractor, are properly licensed at all times under applicable state law and/or regulations and are not debarred, suspended or otherwise ineligible from participation in the Medicaid and/or Medicare program. All health professionals and health care facilities used in the delivery of services by or through the Contractor shall be currently licensed to practice or operate in the State as defined and required by this Contract and the standards specified in the MCO Policy and Procedure Guide, Provider Certification and Licensing.

The Contractor shall ensure that none of its Subcontractors have a Medicaid Contract with the Department that was terminated, suspended, denied, or not renewed as a result of any action of CMS 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. Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or SCHIP except for Emergency Services. Failure to adhere to this provision may result in one or more of the following sanctions:

- 3.1.2.1 The Department may withhold part or all of the Capitation Payment due the Contractor if the service is provided or authorized by unlicensed personnel;
- 3.1.2.2 The Department may refer the matter to the appropriate licensing authority for action;
- 3.1.2.3 The Department may assess liquidated damages as permitted in §13.3 or impose sanctions as described in §13.5 of this Contract.

In the event the Department notifies the Contractor of its discovery that the Contractor's Subcontractor is not properly licensed by the appropriate authority, the Contractor shall immediately remove the Subcontractor from its Provider list and the Subcontractor shall discontinue providing services to Medicaid MCO Members. Upon proper licensing by the appropriate authority and approval by the Department, the Contractor may reinstate the Subcontractor to provide services to Medicaid MCO Members.

3.2 Delegations of Authority

The Contractor shall oversee and remain accountable for all functions and responsibilities of the Contractor arising pursuant to this Contract, including any functions and/or responsibilities the Contractor delegates to a Subcontractor, partner, affiliate, or other party. Agreements between the Contractor and Providers do not constitute delegations of Contractor functions and responsibilities for purposes of this Section 3.2, as Contractor obtains rather than delegates such services. Also, agreements between the Contractor and third parties for the performance of functions not specifically required of the Contractor pursuant to this Contract are not deemed delegations of Contractor functions and responsibilities for purposes of this Section 3.2. In addition to the provisions set forth in Section 5 and Appendix 4, Subcontracts, Contractor agrees to the following provisions:

- 3.2.1 All delegations of functions and/or responsibilities must be made pursuant to a written agreement. The written agreement shall specify the delegated activities and reporting responsibilities of the delegate. The agreement shall also provide for revoking the delegation or imposing other sanctions if the delegate's performance is inadequate.
- 3.2.2 Prior to delegation, the Contractor shall conduct an initial on-site review and evaluate a prospective delegate's ability to perform the activities to be delegated. The Department may require delegates performing the following activities to be accredited or actively pursuing accreditation by a national recognize accrediting body: quality improvement, utilization management, credentialing, and complaints and grievances.
- 3.2.3 The Contractor shall monitor the delegate's performance on an ongoing basis and at least once per year must conduct a review of the subcontractor performance. The Contractor must follow the Department's standards prior to delegating any of the Contractor requirements.
- 3.2.4 If the Contractor identifies deficiencies or areas for improvement related to the delegate's performance of the delegated activity, the Contractor and the delegate shall take corrective action.
- 3.2.5 If the Contractor's delegate subcontracts any of the delegated activity to another, the Contractor's rights and obligations set forth in this Section shall not be amended or altered, and all delegates and sub-delegates shall remain subject to the requirements of this Section. Additionally, the Department must receive prior notice of any further delegation by the Contractor's delegate.
- 3.2.6 The Contractor and all delegates of the Contractor must be in compliance with the requirements in 42 CFR 438.230.

3.3 Credentialing, Delegation of Credentialing and Re-credentialing of Staff

The Contractor must have a written program that complies with 42 CFR 438.12; 438.206, 438.214, 438.224 and 438.230 (2011, as amended) as well as standards defined in the MCO Policy and Procedure Guide.

- 3.3.1 The Contractor shall re-credential all Providers subject to credential every three years.
- 3.3.2 If the Contractor delegates the credentialing to another party, there shall be a written description of the delegation of credentialing activities. The writing must require the delegate to provide assurance that all licensed medical professionals are credentialed in accordance with Department's credentialing requirements and none of the Subcontractors officers, or employees have been excluded from participating in a federal or state program. The Department will have final approval of the delegated entity.
- 3.3.3 The Contractor shall develop and implement policies and procedures for the approval of new providers and the termination or suspension of providers.
- 3.3.4 The Contractor shall develop and implement a mechanism, with the Department approval, for reporting quality deficiencies which result in suspension or termination of a network provider/subcontractor.
- 3.3.5 The Contractor shall develop and implement an appeal process, with the Department's prior approval, for sanctions, suspensions, and terminations imposed by the Contractor against network Providers/Subcontractors.

3.4 Training

The Contractor shall be responsible for training all of its employees, network Providers, and Subcontractors to ensure adherence to the Medicaid MCO Program policies and procedures and Medicaid laws and regulations. The Contractor shall be responsible for conducting ongoing training on Medicaid MCO Program policies and distribution of updates for its network Providers/Subcontractors. The Department reserves the right to attend any and all training programs and seminars conducted by the Contractor. The Contractor shall hold training sessions in several regional locations throughout the state at least once a year. The training plan submitted to the Department must include dates, times, locations and be submitted to the Department no later than September 1, 2012 and July 1st each year thereafter. The Contractor shall provide any updates to the training schedule to the Department at least thirty (30) calendar days prior to the actual date of training. See the MCO Policy and Procedures for additional information.

3.5 Liaisons

The Contractor shall designate an employee of its administrative staff to act as liaison between the Contractor and the Department for the duration of the Contract. The Division of Managed Care will be the Contractor's

point of contact and shall receive all inquiries regarding this Contract and all required reports unless otherwise specified in this Contract. The Contractor shall also designate a member of its senior management who shall act as a liaison between the Contractor's senior management and the Department when such communication is required.

If at any time a designed representative leaves or is changed after execution of this Contract, notice of the new representative shall be rendered in writing to the other party within five (5) business days of the designation.

3.6 Material Changes

The Contractor shall notify Department immediately of any and all material changes affecting the delivery of care or the administration of its health care plan under this Contract. Material changes include, but are not limited to, changes in: composition of the Contractor's Provider network or Subcontractor network; the Contractor's complaint and grievance procedures; health care delivery systems or services; expanded services, benefits, geographic service area or payments; enrollment of a new population; procedures for obtaining access to or approval for health care services; and the Contractor's ability to meet enrollment levels. All changes must be approved in writing by the Department. The Contractor must provide Medicaid MCO Members with a copy of all approved changes at least thirty (30) calendar days prior to the intended effective date of the changes as required by S.C. Code Ann § 38-33-30(c)(Supp. 2000, as amended). The Department shall make the final determination regarding whether a change is material.

The Contractor shall be charged for any changes to its network, website, mailings, Contractor specific services or any other change that requires any alteration or modification of the information provided to Medicaid MCO Members or Providers related to this Contract. The charge will include the actual incremental costs incurred by the Department or its subcontractor/vendor associated with the change. More information may be found in the MCO Policy and Procedure Manual.

3.7 Incentive Plans

The Contractor's incentive plans for its network Providers/Subcontractors shall be in compliance with 42 CFR Part 434 (2010, as amended), 42 CFR §417.479 (2010, as amended), 42 CFR §422.208 and 42 CFR §422.210 (2010, as amended) (see the MCO Policy and Procedure Guide). The Contractor shall submit all information regarding incentives (i.e shared savings, risk, or any other type of non-traditional fee-for-service model arrangements) for review for compliance by the Department.

3.8 Notification of Legal Action

The Contractor shall give the Department notification in writing by certified mail within five (5) business days of being notified of any administrative legal action or complaint filed and prompt notice of any claim made against the Contractor by a Subcontractor or Medicaid MCO Member which may result in litigation related in any way to this Contract.

3.9 Fraud and Abuse Compliance/Program Integrity Plan

The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. These arrangements and procedures must include the following:

- 3.9.1 Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards and regulations.
- 3.9.2 The designation of a compliance officer and a compliance committee both of whom are accountable to senior management.
- 3.9.3 Effective training and education for the compliance officer and the organization's employees.
- 3.9.4 Effective lines of communication between the compliance officer and the Contractor's employees, sub-contractors, and providers.
- 3.9.5 Enforcement of standards through well-publicized disciplinary guidelines.
- 3.9.6 Provisions for internal monitoring and auditing.
- 3.9.7 Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to this Contract.

These policies along with the designation of the compliance officer and committee must be submitted to the Department for approval upon initiation of this contract and then whenever changes occur.

The Contractor must immediately report to the Department any suspicion or knowledge of fraud and abuse including, but not limited to, the false or fraudulent filings of claims and the acceptance of or failure to return monies allowed or paid on claims known to be fraudulent. See the MCO Policy and Procedure Guide for additional guidance.

3.10 Ownership and Control

The Contractor shall provide the Department with full and complete information on the identity and address of each person or corporation with an ownership or control interest as described in 42 CFR 455.101 (2010, as amended), including officers, directors and partners and persons with direct and/or indirect ownership interests (mortgage, deed of trust, note or other obligation secured by the disclosing entity) totaling five percent (5%) or more in the health plan, or any Subcontractor in which the Contractor has a five percent (5%) or more ownership interest in accordance with 42 CFR 455 (2010, as amended). This information shall be provided to the Department on the approved Disclosure of Ownership and Control Interest Statement and updated whenever changes in ownership occur.

3.11 Excluded Parties

The Contractor shall check the Excluded Parties List Service administered by the General Services Administration, when it enrolls any provider or subcontractor, to ensure that it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other agreement with debarred individuals for the provision of items and services that are the Contractor's contractual obligation. The Contractor shall also report to the Department any network Providers or Subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery.

3.12 Department Policies and Procedures

The Contractor shall comply with the applicable policies and procedures of the Department, specifically including without limitation the policies and procedures for MCO services, and all policies and procedures applicable to each category of Covered Benefits and the services related to the delivery of those Covered Benefits as required by the terms of this Contract. In no instance may the Contractor impose limitations or exclusions with respect to Covered Benefits and related services that are more stringent than those specified in the Department's applicable MCO Policies and Procedures. The Department use best efforts to provide prior written notice to Contractor of applicable material changes to its policies and procedures that alter the terms of this Contract.

3.13 State and Federal Law

At all times during the term of this Contract and in the performance of every aspect of this Contract, the Contractor shall strictly adhere to all applicable federal and state law (statutory and case law), regulations and standards, in effect when this Contract is signed or which may come into effect during the term of this Contract.

Any change mandated by the Affordable Care Act (ACA) which may pertain to MCOs and/or Medicaid Services shall be implemented by the Contractor. One such requirement listed in Section 2501 of ACA pertains to the states collecting drug rebates for drugs covered under a MCO. The Contractor shall create and transmit a file according to the Department's format which will allow for the Department or its subcontractors/vendors to bill drug rebates to manufacturers. The Contractor shall fully cooperate with the Department and the Department's subcontractors/vendors to ensure file transmissions are complete, accurate and delivered by the Department's specified deadlines. In addition, the Contractor shall assist and provide detailed Claim information requested by the Department or the Department's subcontractors/vendors to support rebate dispute and resolution activities. The Department will review the ACA requirements and if it determines the new requirements will significantly increase cost to the Contractor, the Department will work with its actuary to adjust the Contractor's Capitation Payment at the next scheduled rate adjustment.

4 SERVICES

The Contractor shall possess the expertise and resources to ensure the delivery of quality health care services to Medicaid MCO Members in accordance with the Medicaid Program standards and the prevailing medical community standards. The Contractor shall adopt practice guidelines that:

- Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field
- Consider the needs of the Medicaid MCO Members.
- Are adopted in consultation with contracting health care professionals.
- Are reviewed and updated periodically as appropriate.

The Contractor shall disseminate the guidelines to all affected providers and, upon request, to Medicaid MCO Members and potential Medicaid MCO Members. Decisions for utilization management, Medicaid MCO Member education, coverage of services and other areas to which guidelines apply should be consistent with the guidelines.

4.1 Core Benefits the South Carolina Medicaid MCO Program

Core Benefits shall be available to each Medicaid MCO Member within the Contractor's Service Area and the Contractor shall provide a mechanism to reduce inappropriate and duplicative use of health care services. Services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under Medicaid fee-for-service. In the event the amount, duration and/or scope of services is modified under the Medicaid fee-for-service program, the Department, in its discretion, may exempt the Medicaid MCO Program from the modification. The Contractor:

- 4.1.1 Shall ensure that services are sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- 4.1.2 May not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the Medicaid MCO Member.
- 4.1.3 May place appropriate limits on a service (a) on the basis of certain criteria, such as Medical Necessity; or (b) for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.

The Contractor shall provide all of the Core Benefits consistent with and in accordance with the standards as defined in the State Plan. Services shall be furnished up to the limits as specified in the minimum service requirements outlined in the MCO Policy and Procedure Guide. No medical service limitation can be more restrictive than those that currently exist under the State Plan. In the provision of certain maternity services, the Contractor shall provide services in accordance with 42 CFR Part 440 Subpart B (2010, as amended). The summary listing of these Core Benefits are outlined in the MCO Policy and Procedure Manual.

In the provision of Core Benefit services outlined and defined in the MCO Policy and Procedure Guide, the Contractor shall be required to provide Medically Necessary and appropriate care to Medicaid MCO Members under this Contract. The Department shall make the final interpretation of any disputes about medical necessity and continuation of Core Benefits covered under this Contract. The decision by the Department will be considered final.

The Contractor shall ensure the Core Benefits are provided as defined and specified in the Contract and in MCO Policy and Procedure Guide. Service limits such as a drug formulary may be implemented; however, there must be a mechanism to cover drugs outside the formulary if they are determined to be medically necessary in the treatment of a particular Medicaid MCO Member. The Contractor will authorize the pharmacist to issue a five days' supply to the Medicaid MCO Member. If the Contractor cannot resolve the prescription issue within those five days, the Contractor will approve the prescription for at least thirty (30) days. At no time during this process will the Contractor require the Medicaid MCO Member's involvement or participation in the resolution of prescription issue as a condition for continuing the prescription. Information regarding coverage allowance for a non-formulary product shall be disseminated to Medicaid MCO Members in the Medicaid MCO Member's handbook and to Providers in the Contractor's Provider Manual.

If the Contractor elects not to provide, reimburse for or provide coverage of a counseling or referral service because of an objection on moral or religious grounds, the Contractor must furnish information about the services it does not cover, as follows:

- To the Department, with its application for a Medicaid contract or whenever the Contractor adopts the policy during the term of the contract.
- To potential enrollees before and during enrollment.
- To enrollees within ninety (90) calendar days after adopting the policy.
- Effective October 1, 2012 the Contractor must maintain a list of Providers who do not participate in family planning and make that list available to the enrollment broker and the Department by the 15th of each month.

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

The Contractor shall have written procedures for notification, tracking, and follow-up to ensure EPSDT services will be available to all eligible Medicaid MCO Program children and young adults. The requirements for provision of EPSDT services are outlined in the MCO Policy and Procedure Guide.

The Contractor shall assure that all Medically Necessary, Medicaid-covered diagnosis, treatment services and screenings are provided, either directly, through subcontracting, or by Referral. The utilization of these services shall be reported as referenced in the MCO Policy and Procedure

Guide. Expenditures for the medical services as previously described have been factored into the Capitation Payment described in §2.1 of this Contract and the Contractor will not receive any additional payments related to these EPSDT services.

4.3 Emergency Medical Services

The Contractor shall provide that Emergency Services and post-stabilization services be rendered without the requirement of prior authorization of any kind and advise all Medicaid MCO Members of the provisions governing in and out of Service Area use of Emergency Services. The Contractor's protocol for provision of Emergency Services must specify the circumstances under which the Emergency Services will be covered when furnished by a Provider with whom the Contractor does not have contractual or referral arrangements. The Contractor shall make prompt payment for covered Emergency Services that are furnished by Providers that have no arrangements with the Contractor for the provision of such services. The attending emergency physician or the Provider actually treating the Medicaid MCO Member shall determine when the Medicaid MCO Member is sufficiently stabilized for transfer or discharge.

The Contractor shall not limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The Contractor shall not refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Medicaid MCO Member's PCP, MCO or applicable state entity of the Medicaid MCO Member's screening and treatment within ten (10) calendar days of presentation for Emergency Services. The Contractor shall not deny payment for treatment when a representative of the entity instructs the Medicaid MCO Member to seek Emergency Services. The Contractor shall not deny payment for treatment obtained when a Medicaid MCO Member had an Emergency Medical Condition and the absence of immediate medical attention would have had the outcomes specified in 42CFR 438.114(a) of the definition of Emergency Medical Condition.

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

- 1) Determining if an emergency exists for Medicaid MCO Members when the medical screening service is performed.
- 2) Treatment as may be required to stabilize the medical condition.
- 3) Transfer of the individual to another medical facility within Social Security Act Section 1867 (42 U.S.C. 1395 dd) guidelines and other applicable state and federal regulations.

The Contractor shall prior approve any services performed after the Provider, whether in or out of the network Service Area, has stabilized the patient. The Contractor shall cover services subsequent to stabilization:

- 1) That were pre-approved by the Contractor,
- 2) That were not pre-approved by the Contractor because the Contractor did not respond to the provider of post-stabilization

- care services' request for pre-approval within one (1) hour after the request was made,
- 3) if the Contractor could not be contacted for pre-approval,
 - 4) if the Contractor and the treating physician cannot reach an agreement concerning the Medicaid MCO Member's care and a network physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a network physician and the treatment physician may continue with the care of the member until a network physician is reached or one of the criteria of 42 CFR 422.113(c)(3) is met.

A Medicaid MCO Member who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

Expenditures for the medical services as previously described in this Section 4.3 have been factored into the Capitation Payment described in §2.1 of this Contract and the Contractor will not receive any additional payments.

The Contractor shall limit charges to Medicaid MCO Members for any post-stabilization care services to an amount no greater than what the Contractor would charge the Medicaid MCO Member if he/she had obtained the services through one of the Contractor's Providers. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when 1) a network physician with privileges at the treating hospital assumes responsibility for the Medicaid MCO Member's care, 2) a network physician assumes responsibility for the Medicaid MCO Member's care through transfer, 3) a representative of the Contractor and the treating physician reach an agreement concerning the Medicaid MCO Member's care, or 4) the Medicaid MCO Member is discharged.

4.4 Hysterectomies

The Contractor shall cover the cost of hysterectomies when they are non-elective and Medically Necessary as provided in 42 CFR §441.255 (2010, as amended). Non-elective, Medically Necessary hysterectomies shall meet the requirements as outlined in the MCO Policy and Procedure Guide. Expenditures for the medical services as previously described in this Section 4.4 have been factored into the Capitation Payment described in § 2.1 of this Contract and the Contractor will not receive any additional payments for these services.

4.5 Sterilization

The Contractor shall provide sterilization services in accordance with 42 CFR 441 Subpart F. Sterilization for a male or female must also meet the requirements as outlined in the MCO Policy and Procedure Guide. Expenditures for the medical services previously described have been factored into the Capitation Payment described in § 2.1 of this Contract and the Contractor will not receive any additional payment for these

services. (This Section 4.5 is not applicable if the Contractor is operating under §1.8 of this Contract).

4.6 Limitations on Abortions

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

The Contractor understands and agrees that the Department shall not make payment to the Contractor for any health benefits coverage under this Contract if any abortion performed hereunder violates federal law or regulations. The term "health benefits coverage" as used in this Section 4.6 shall mean the package of services covered by the Contractor pursuant to a contract or other arrangement. (This Section 4.6 is not applicable if the Contractor is operating under Section 1.8 of this Contract).

4.7 Medical Services for Special Populations

The Contractor shall implement mechanisms to assess each Medicaid MCO Member identified by the Department and identified to the Contractor by the Department as having special health care needs in order to identify any ongoing special condition of the Medicaid MCO Member that requires a course of treatment or regular care monitoring. The assessment mechanism must use appropriate Health Care Professionals. The Contractor must have a mechanism in place to allow Medicaid MCO Members to directly access a specialist as appropriate for the member's condition and identified needs (for example, through the standard referral or an approved number of visits).

The Contractor shall determine the need for any enhanced services that may be necessary for these populations to maintain their health and well-being. The MCO Policy and Procedure Guide outlines the best practices and procedures that the State Plan uses to serve the designated special populations. Expenditures for the health care services of the special populations as previously described in this Section 4.7 have been factored into the Capitation Payment described in § 2.1 of this Contract and the Contractor will not receive any additional payments for these services.

Children with chronic/complex health care needs and all infants of high risk mothers are defined as special populations in the State Plan. The special populations are identified as individuals that may require additional health care services that should be incorporated into a health management plan which guarantees that the most appropriate level of care is provided for these individuals.

4.8 Excluded Services

The MCO Policy and Procedure Guide provides detailed information on the services that will not be covered/reimbursed by the current Medicaid program

4.9 Additional Services and Incentives

The Contractor or may offer Additional Services to enrolled Medicaid MCO Members. These Additional Services are health care services which are non-covered services by the South Carolina State Plan for Medical Assistance and/or which are in excess of the amount, duration, and scope of those listed in the MCO Policy and Procedure Guide. These Additional Services shall be specifically defined by the Contractor in regard to amount, duration and scope. SCDHHS will not provide any additional reimbursement for these Additional Services. Transportation for these Additional Services is the responsibility of the Medicaid MCO Member and/or Contractor. The Contractor shall provide SCDHHS with a description of the Additional Services being considered by the Contractor for approval prior to any Additional Services being offered. Upon approval by SCDHHS, Additional Services shall be included and incorporated as a part hereof to the Contractor and included in the Contractor's marketing information. The Contractor must notify their current Medicaid MCO Member at least thirty (30) days prior to deletions or modifications to the approved Additional Services made during the Contractor year. Contractor must submit those changes to SCDHHS for approval prior to the thirty (30) day notices to the Medicaid MCO Member. All changes must be submitted in time to change the benefit grid to coincide with the deletions or modification any of the Additional Services, in accordance with requirements listed in the MCO Policy and Procedure Guide. Any cost, charges or expenses incurred by SCDHHS or its designee including but not limited to changes to the website grids, member and provider notifications or any other related requirements are the responsibility and will be paid by the Contractor.

Incentives are defined as those items that a Contractor provides to a Medicaid MCO Member that encourage a Medicaid MCO Member to change or modify behaviors or meet certain goals. An example of an Incentive is a gift card or other type product. These Incentives shall be specifically defined by the Contractor in regard to amount, duration and scope. SCDHHS will not provide any additional reimbursement for these Incentives. If transportation is part of these Incentives, it will be the responsibility of the Medicaid MCO Member and/or Contractor. The Contractor shall provide SCDHHS with a description of the Incentives to be offered by the Contractor for approval prior to and Incentive being offered. Upon approval by SCDHHS, Incentives shall be included and incorporated as a part hereof to the Contractor and included in the Contractor's marketing information. The Contractor must notify their current Medicaid MCO Member at least thirty (30) days prior to deletions or modifications to the approved Incentives made during the Contractor year. Contractor must submit those changes to SCDHHS for approval prior to the thirty (30) day notices to the Medicaid MCO Member. All changes must be submitted in time to change the benefit grid to coincide with the deletions or modification of any Incentives, in accordance with

requirements listed in the MCO Policy and Procedure Guide. Any cost, charges or expenses incurred by SCDHHS or its designee including but not limited to changes to the website grids, member and provider notifications or any other related requirements are the responsibility and will be paid by the Contractor.

4.10 Care Coordination

The Contractor shall ensure that each Medicaid MCO Member has an ongoing source of Primary Care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the Medicaid MCO Member. The Contractor shall be responsible for the planning, directing and coordinating of health care needs and services for Medicaid MCO Members through Care Coordination, increased accessibility of services and promoting prevention. The Contractor's Care Coordination and Referral activities must incorporate and identify appropriate methods of assessment and Referral for Medicaid MCO Members requiring both medical and behavioral health services. These activities must include assessment, scheduling assistance, monitoring and follow-up for its Medicaid MCO Member(s) needing or requiring both medical and behavioral health services. The Contractor must submit the list of Primary Care Providers, including obstetricians, with the Contractor's Medicaid MCO Members assigned to those Primary Care Providers to the Department in its monthly submissions in the format as outlined in the MCO Policy and Procedures Manual and Appendix 6.

4.10.1 Referral System

The Contractor shall provide the coordination necessary for the referral of its Medicaid MCO Members to Specialty Providers and to out of plan services that may be available through fee-for-service Medicaid Providers. The Contractor shall provide the Department a copy of its referral and monitoring process for services included in the Core Benefits and Additional Services. A list of fee-for-service benefits is outlined in Section 4.8 and defined in the MCO Policy and Procedure Guide. These services will continue to be provided by Medicaid and are consistent with the outline and definition of covered services in the State Plan. Payment for these services will remain fee-for-service, unless the Contractor chooses to offer them as an Additional Services.

4.10.2 Continuity of Care

The Contractor shall develop and maintain effective continuity of care activities to ensure a continuum approach to treating and providing health care services to Medicaid MCO Members. In addition to ensuring appropriate referrals, monitoring, and follow-up to Providers within the network, the Contractor shall ensure appropriate linkage and interaction with Providers outside the network. The Contractor's continuity of care activities should provide processes for effective interactions between Medicaid MCO Members and network Providers and identification and

resolution of problems if those interactions are not effective or do not occur.

The Contractor shall provide effective continuity of care activities to ensure that the appropriate personnel, including the PCP, are kept informed of the Medicaid MCO Member's treatment needs, changes, progress or problems. The Contractor shall ensure that service delivery is properly monitored to identify and overcome any barriers to primary and preventive care that the Medicaid MCO Member may encounter.

Unless otherwise required by this Contract, the Contractor shall not be obligated to directly furnish and pay for any services outside the Core Benefits except those included in the Additional Services as stipulated in this Contract. The Contractor shall assist the Medicaid MCO Member in determining the need for services outside the Core Benefits and refer the member to the appropriate Provider. The Contractor shall establish a process to coordinate the delivery of Core Benefits with services that are reimbursed fee-for-service by the Department. The Contractor may request the assistance of the Department for the referral to the appropriate service setting. In the event of termination of a Contractor's Provider the Contractor will continue to pay the Provider until either the Medicaid MCO Member has finished the course of treatment or until the Provider releases the Medicaid MCO Member to another Provider who is within the Contractor's network.

4.10.3 Targeted Case Management Services

The Contractor shall be responsible for developing a system for coordinating health care for Medicaid MCO Members that require Targeted Case Management (TCM) services that avoids duplication and ensures that the Medicaid MCO Member's needs are adequately met. TCM services are those services which will assist an individual eligible under the State Plan in gaining access to needed medical, social, educational and other services to include a systematic referral process to the service with documented follow-up. TCM services are available to alcohol and substance abuse individuals, children in foster care, chronically mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with mental retardation or a related disability, individuals with head or spinal cord injury or a related disability, children and adults with sickle cell disease and adults in need of protective services. Patients who are dually diagnosed with complex social and medical problems may require TCM services from more than one case management provider. A systematic referral process to Providers for medical education, legal and rehabilitation services with documented follow up to ensures that the necessary services are available and accessed for each eligible patient. TCM services available to members are outlined in MCO Policy and Procedure Guide.

The Department has developed a Case Management Hierarchy to avoid duplication and to ensure the members' needs are adequately met. TCM programs will remain fee-for-service as listed in MCO Policy and Procedure Guide. The Contractor and the Case Management Agency shall develop a system for exchanging information.

4.10.4 School-Based Services

School-based services are those Medicaid services provided in school districts to Medicaid eligible children under the age of 21. Medicaid providers of these services will continue to be reimbursed fee-for-service for these services. The Contractor shall at a minimum have written procedures for promptly transferring medical and developmental data needed for coordinating ongoing care with school-based services.

4.10.5 Institutional Long Term Care Facilities/Nursing Homes

The Contractor is responsible for reimbursing the long-term care facility/nursing home/hospital who provides Swing Beds or Administrative Days, for the first ninety (90) continuous days of services in a long-term care/nursing home placement as specified in MCO Policy and Procedure Guide

The Contractor is responsible for notifying the Department of any Medicaid MCO Members requiring institutionalization in a long term care facility/nursing home. See Section 10.7 of this Contract and the MCO Policy and Procedure Guide.

Once the Medicaid MCO Member has been approved for and admitted to a long term care facility/nursing home the Contractor will be responsible for payment for long term care. The Contractor is responsible for ninety (90) continuous days after which the Medicaid MCO Member can be disenrolled at the earliest effective date allowed by system edits. All costs associated with long term care have been factored into the Capitation Payment. See MCO Policy and Procedure Guide for details.

4.10.6 Psychiatric Services

The Contractor is required to provide limited psychiatric services as specified in MCO Policy and Procedure Guide. The following treatment services will be reimbursed by Department on a fee-for-service basis:

Hospital Services (UB04 claims)

- Hospital Services provided at a psychiatric hospital in accordance with MCO Policy and Procedure Guide

Physician/Clinic (CMS 1500 claims)

- Physician Services provided by the Department of Alcohol and Other Drug Abuse Services (DAODAS);

- Services provided by the Department of Mental Health (DMH).
As outlined in the MCO Policy and Procedures Guide

4.10.7 Coordination of Referral Outside of Core Benefits

The Contractor 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 State Plan. These services include, but are not limited to TCM 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.

4.11 Family Planning and Communicable Disease Services

4.11.1 Family Planning Services

Family Planning Services are available to help prevent unintended or unplanned pregnancies. Family Planning Services include examinations, assessments, and traditional contraceptive devices. The Contractor should agree to make available all family planning services to Medicaid MCO Members as specified in MCO Policy and Procedure Guide. Medicaid MCO Members shall have the freedom to receive Family Planning Services outside the Contractor's Provider network by appropriate Medicaid Providers without any restrictions. For Medicaid MCO Members who elect to receive Family Planning Services outside the Contractor's Provider network, the enrolled Medicaid Provider will bill the Department to be reimbursed by the Department fee-for-service. Medicaid MCO Members should be encouraged by the Contractor to receive Family Planning Services through the Contractor's network of Providers to ensure continuity and coordination of a Medicaid MCO Member's total care. No additional reimbursements shall be made to the Contractor for Medicaid MCO Members who elect to receive Family Planning Services through the Contractor's Provider network. (This Section 4.11.1 is not applicable if the Contractor is operating under §1.8 of this Contract).

4.11.2 Communicable Disease Services

The Contractor shall provide to Medicaid MCO Members communicable disease services, which are those services available to help control and prevent diseases such as tuberculosis (TB), sexually transmitted diseases (STDs), and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) infection, as specified in MCO Policy and Procedure Guide.

4.11.2.1 Prompt Reporting of South Carolina Reportable Diseases, and Access to Clinical Records of Patients with Reportable Diseases

The Contractor or its network Providers shall comply with S.C. Code Ann. §§ 44-1-80 through 44-1-140 and §§ 44-29-10 through 44-29-90 by reporting all instances/occurrences of TB, STDs and HIV/AIDS infection to the state public health agency within twenty-four (24) hours of notification by Provider or from date of service. Refer to the annual issue of "Epi-Notes", DHEC's Disease Prevention and Epidemiology Newsletter for the list of reportable conditions by physicians and health care institutions required under State law and listed in MCO Policy and Procedure Guide.

4.11.2.2 Control and Prevention of Communicable Diseases

The Contractor and/or its network Provider for clinical management, treatment and direct observed therapy must refer suspected and actual TB cases to DHEC. DHEC is the state public health agency responsible for promoting and protecting the public's health and has the primary responsibility for the control and prevention of communicable diseases such as TB, STDs, HIV/AIDS infection and vaccine preventable diseases. DHEC provides a range of primary and secondary prevention services through its local health clinics to provide and/or coordinate communicable disease control services. This care will be coordinated with the Contractor's PCP.

4.11.2.3 Patient Confidentiality

DHEC will promote coordination of care while ensuring patient confidentiality. Notwithstanding §4.10.2 of this Contract, in compliance with S.C. Code Ann. §44-29-135 (Supp. 2000, as amended), for Medicaid MCO Members who choose diagnosis and treatment for TB, STDs, or HIV/AIDS infection in the state public health clinics, information regarding their diagnosis and treatment will be provided to the Contractor's PCP assigned to that Medicaid MCO Member only with the written consent of the Medicaid MCO Member, unless otherwise provided by law.

4.12 Manner of Service Delivery and Provision

In establishing and maintaining the service delivery network, the Contractor must consider the following:

- The anticipated Medicaid enrollment.
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the geographical service area being considered by the Contractor.

- The number of network Providers who are not accepting new Medicaid patients.
- The geographic location of Providers and Medicaid MCO Members, considering distance travel time, means of transportation ordinarily used by Medicaid MCO Members, and whether the location provides physical access for Medicaid MCO Members with disabilities.

The Contractor shall provide female Medicaid MCO Members with direct access to a women's health specialist within the network for Covered Services necessary to provide women's routine and preventive health care services. This is in addition to the Medicaid MCO Member's designated source of primary care if that source is not a women's health specialist. The Contractor shall provide a second opinion from a qualified Health Care Professional within the network or arrange for the Medicaid MCO Member to obtain one outside the network at no cost to the Medicaid MCO Member. If the network is unable to provide necessary Covered Services to a particular Medicaid MCO Member, the Contractor shall adequately and timely cover these services out of network for the Medicaid MCO Member for as long as the Contractor is unable to provide them. The Contract will require any out-of-network Providers to coordinate with the Contractor with respect to payment to ensure that any cost to the Medicaid MCO Member is no greater than it would be if the services were furnished within the network.

4.12.1 Service Area

The Contractor shall attach a copy of and describe its Medicaid Service Area as approved by the Department. The attachment shall be incorporated herein as part of the Contract. Any changes to the Contractor's Service Area must be approved by the Department at least thirty (30) days prior to the effective date of the change, except in the event the change triggers a Medicaid MCO Member notification requirement, then Contractor must have changes approved one hundred and twenty days (120) calendar days prior to the effective date of the change.

4.12.2. Adequacy of Providers

The Contractor shall maintain appropriate levels, as determined by the Department, of organizational components, including, but not limited to PCPs, Specialty Providers, hospitals and other Health Care Providers necessary for the provision of the services under this Contract.

The Contractor shall establish and maintain Provider networks and in-area referral Providers in sufficient numbers, as determined by the Department, to ensure that all Covered Services are available and accessible in a timely manner within the Contractor's Service Area in accordance with § 4 and as approved by the Department.

The Contractor shall make available and accessible, as determined by the Department, hospitals, facilities, and professional personnel sufficient to provide the required Core Benefits.

The locations of facilities, PCPs, and network Providers must be sufficient in terms of geographic convenience to low-income and rural areas as determined by the Department.

The Department's detailed standards, criteria and requirements for county network submissions and ongoing review are located in the MCO Policy and Procedure Guide.

Services to a Medicaid MCO Member shall be provided in the same manner as those services that are provided to the Medicaid Fee-For-Service members or by the other MCOs in the same county or location. The services shall be as accessible to Medicaid MCO Members as they are for non-Medicaid members residing in the same geographic service area.

The Contractor shall notify the Department immediately of any changes to the composition of its Provider network and/or subcontractors that adversely affects its ability to make available all Core Benefits in a manner as outlined in § 4 of this Contract and the MCO Policy and Procedure Guide. The Contractor shall have procedures to address changes in its Provider network that negatively affect the ability of Medicaid MCO Members to access all services available within the county or geographic location as determined by the Department. Changes in Provider network composition that are not prior approved by the Department and/or that impair the Medicaid MCO Member's access to services will be considered as grounds for Contract termination or removal from the county or geographical area as determined by the Department. The Contractor understands and agrees that notwithstanding the execution of this Contract, neither the Contractor nor its Subcontractor/network Provider shall provide any services to a Medicaid MCO Member until the Contractor has an adequate Provider network verified and approved by the Department.

If during the annual review of the Provider Network Listing Spreadsheet, or during any review conducted at the discretion of the Department, it is determined the Contractor no longer meets the network adequacy standards for a county or counties, the Department shall reserve the right to implement MCO Provider Network Termination and/or Transition Plan, as described in the MCO Policy and Procedure Guide, whether or not a material change in the Contractor's network has occurred.

The Contractor is responsible for all financial costs or charges associated with termination or transition of its Provider network(s), including, but not limited to, costs or charges associated with changes to the enrollment broker's website, computer system any mailings by the enrollment broker and/or Department costs or charges associated with the process of termination or transitioning a Contractor in a county or counties.

The Department may also, in its sole discretion, suspend new enrollments into the Contractor's health plan, including auto-

enrollments and choice, in the affected county or counties including the surrounding counties during the MCO Provider Network Termination/Transition Plan period or until the Contractor has demonstrated that it will be able to maintain an adequate network in the county and surrounding counties. As a part of the MCO Provider Network Termination/Transition Plan, the Contractor must terminate all of its Provider contracts within the terminated counties.

The Department may at its discretion impose a daily charge as outlined in Section 13.3

4.12.3. Contractor's Network Composition

The Contractor shall not discriminate 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. The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who serves high-risk populations or specializes in conditions that require costly treatment. If the Contractor declines to include individual or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision and a copy must be sent to the Department's Bureau of Managed Care Director. The Contractor shall provide adequate access, as determined by Department, either through employment or subcontracting, to Providers for PCP Referrals, specialty services and/or ancillary medical services to ensure that these services are available in accordance with § 4 of this Contract.

4.12.3.1 Primary Care Providers (PCP)

A PCP in the Contractor's Provider network must be a physician who provides or arranges for the delivery of medical services, including case management, to assure that all services, which are found to be medically necessary, are made available in a timely manner as outlined in § 4 of this Contract. The PCP may practice in a solo or group setting or may practice in a clinic (i.e., Federally Qualified Health Center or Rural Health Center). The Contractor shall agree to provide at least one (1) full time equivalent (FTE) PCP within a thirty (30) mile radius of the Medicaid MCO Members' location and is accepting new or existing Medicaid MCO Members. An FTE PCP means that the PCP is in the same location for at least three (3) business days per week and its membership does not exceed the capacity to see Medicaid MCO Members within the prescribed timeframes as outlined in Section 4 of this Contract.

Each Medicaid MCO Member shall be given the opportunity to choose a specific PCP within the Contractor's Provider network who will be responsible for

the provision of primary care services and the coordination of all other health care needs. Medicaid MCO Members who do not make a choice of a PCP within fourteen (14) calendar days after being assigned to the Contractor shall be contacted by the Contractor to assist the member in choosing a PCP. If the Contractor is unable to contact the newly assigned Medicaid MCO Member, it shall assign a PCP to the Medicaid MCO Member. The Contractor shall submit to the Department a copy of the procedures to be used to contact Medicaid MCO Members for initial education for approval with this executed Contract, upon any change of the procedures and upon request by the Department. These procedures shall adhere to the enrollment process and procedures outlined in Section 6 of this Contract and the post enrollment procedures required in Section 8 of this Contract.

The Contractor must allow the Medicaid MCO Member to request a change of PCP within certain time frames and guidelines established by the Contractor, which must not conflict with the federal rules and regulations governing said time frames.

The Contractor shall identify to the Department, or its subcontractor/vendor, on a monthly basis any PCP approved to provide services under this Contract who will not accept new patients.

The PCP shall serve as the Medicaid MCO Member's initial and most important point of interaction with Contractor's Provider network. The Contractor shall assure that the PCP shall, at a minimum:

- 4.12.3.1.1 Manage the medical and health care needs of Medicaid MCO Members to assure that all Medically Necessary services are made available in a timely manner;
- 4.12.3.1.2 Monitor and follow-up on care provided by other medical service Providers for diagnosis and treatment, to include services available under Medicaid fee-for-service;
- 4.12.3.1.3 Provide the coordination necessary for the referral of Medicaid MCO Members to specialists and to services that may be available through Medicaid fee-for-service; and

- 4.12.3.1.4 Maintain a medical record of all services rendered by the PCP and other referral Providers.

4.12.4 Specialty Providers

The Specialty Provider must comply with all applicable statutory and regulatory requirements of the Medicaid and the Program; be eligible to participate in Medicaid and the Program; and be board certified or admissible.

The Contractor shall assure that a Specialty Provider shall, at a minimum:

4.12.4.1 Provide consultation summaries or appropriate periodic progress notes to the Medicaid MCO Member's PCP on a timely basis, following a referral or routinely scheduled consultative visit;

4.12.4.2 Notify the Medicaid MCO Member's PCP when scheduling a hospital admission or any other procedure requiring the PCP's approval;

The Contractor shall ensure the availability of Specialty Providers as appropriate for both adult and pediatric Medicaid MCO Members. The Contractor shall ensure access to appropriate service settings for Medicaid MCO Members needing medically high risk perinatal care, including both prenatal and neonatal care.

4.12.5 Other Ancillary Medical Service Providers

Ancillary medical service Providers including, but not limited to, ambulance services, durable medical equipment, home health services, pharmacies and x-ray/laboratories must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations.

4.12.6 Hospital Providers

Hospital Providers must be qualified to provide services under the Medicaid program. All services must be provided in accordance with applicable state and federal laws and regulations.

4.13 Service Accessibility Standards

The Contractor and its network Providers/Subcontractors shall ensure access to health care services (distance traveled, waiting time, length of time to obtain an appointment, after-hour care) in accordance with the prevailing medical community standards for the services provided under this Contract. The Department will monitor the Contractor's service accessibility. The Contractor shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, and professional, allied and para-medical personnel for the provision of

Covered Services, including all Emergency Services, on a 24-hour-a-day, 7-days-a-week basis, and shall take corrective action if any provider fails to comply. At a minimum, this shall include:

4.13.1 Twenty-Four (24) Hour Coverage

The Contractor shall ensure that all Emergency Services are available on a twenty-four (24) hours a day, seven (7) days a week basis through its network Providers, and shall maintain, twenty-four (24) hours per day, seven (7) days per week telephone coverage to instruct Medicaid MCO Members on where to receive Emergency Services and Urgent Care.

The Contractor's network Provider/Subcontractor 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 the Department.

4.13.2 Travel Time and Distance

The Contractor shall ensure that, in accordance with usual and customary practices, PCP services are available on a timely basis.

Services are generally considered accessible if they reflect usual practice and travel arrangements in the local area. Generally, this is within a thirty (30) mile radius from a Medicaid MCO Member's residence. Exceptions may be made if the travel distance for medical care exceeds thirty (30) miles.

Other Providers participating in the Contractor's managed care delivery system also must be geographically accessible to Medicaid MCO Members, as outlined in the MCO Policy and Procedure Guide.

4.13.3 Scheduling/Appointment Waiting Times

The Contractor shall ensure that its PCPs 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:

- 4.13.3.1 Routine visits shall be scheduled within four (4) to six (6) weeks;
- 4.13.3.2 Urgent Care visits shall be scheduled within forty-eight (48) hours;
- 4.13.3.3 Emergency Services shall be provided immediately upon presentation at a service delivery site; and
- 4.13.3.4 Waiting times shall not exceed forty-five (45) minutes for a scheduled appointment of a routine nature.

Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Walk-in patients with urgent needs should be seen within forty-eight (48) hours.

The Contractor's network Providers/Subcontractors 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.

4.14 Authorization and Referral System

The Contractor shall have a referral system for Medicaid MCO Members requiring specialty health care services.

The Contractor must require written evidence of the communication of the Medicaid MCO Member's results/information to the referring physician by the Specialty Provider or continued communication of the Medicaid MCO Member's patient information between the Specialty provider and the PCP.

4.15 Cultural Considerations

The Contractor shall promote the delivery of services in a culturally competent manner to all Medicaid MCO Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

4.16 Prior Authorization of Pharmacy and Durable Medical Equipment

In the event a Medicaid MCO Member entering the Contractor's health plan is receiving Medicaid covered pharmacy and/or durable medical equipment services the day before enrollment, whether such services were provided by another MCO or Medicaid fee-for-service, the Contractor shall be responsible for the costs of the continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The Contractor shall provide continuation of such services for up to thirty (30) calendar days or until the Medicaid MCO Member may be transferred without disruption, whichever is less. The Contractor must also honor any prior authorization for pharmacy and/or durable medical equipment services issued while the Medicaid MCO Member was enrolled in another MCO or the Medicaid fee-for-service program for a period of thirty (30) calendar days after the Medicaid MCO Member's enrollment in the Contractor's health plan. In addition, for Medicaid MCO Members with the following conditions, the Contractor must provide continuation of pharmaceutical services and/or honor a prior authorization an additional thirty (30) calendar 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/hyperactivity disorder. Additional information regarding this requirement may be found in the MCO Policy and Procedure Guide.

5 PROVIDER SUBCONTRACTS

The Contractor shall provide or assure the provision of all Covered Services specified in of this Contract. The Contractor may provide these services directly or may enter into subcontracts with Providers who will provide services to the Medicaid MCO Members in exchange for payment by the Contractor for services rendered. Subcontracts are required with all Providers of services, unless otherwise previously approved by the Department.

All subcontracts for the provision of services under this Contract shall contain verbatim the section containing all federal, state and Department requirements as outlined in Appendix/Attachment Four (4) which shall supersede all other requirements of the subcontract.

The Contractor shall submit a version of each subcontract it intends to use with its Providers and Subcontractor to enable the Department to validate the proper inclusion of Appendix/Attachment Four (4) See the MCO Policy and Procedure Guide for more details regarding this requirement.

The Contractor shall require each such Subcontractor to covenant and agree that in the event of a breach of the Subcontract by the Contractor, termination of the Subcontract, or insolvency of the Contractor, each Subcontractor shall (i) provide all services and fulfill all of its obligations pursuant to the Subcontract for the remainder of any month for which the Department has made payments to the Contractor, and (ii) fulfill all of its obligations respecting the transfer of Medicaid MCO Members to other Providers, including record maintenance, access and reporting requirements. All such covenants, agreements, and obligations expressed in this paragraph shall survive the termination of this Contract or any Subcontract. Additional information regarding these requirements may be found in the MCO Policy and Procedure Guide.

The Contractor shall pay 90% of all clean claims from Providers within thirty (30) days of the date of receipt. The Contractor shall pay 99% of all clean claims from Providers, within ninety (90) days of the date of receipt. The date of receipt is the date as indicated by its data stamp on the claim. The date of payment is the date of the check or other form of payment. The Contractor and its providers may, by mutual agreement, establish an alternative payment schedule. Any alternative payment timeframe schedule must be stipulated in the Contract. The Department may conduct audits of the Contractor by using the date of service and date of payment to identify and audit the Contractor to ensure the Contractor is adhering to the requirement. If a Contractor has an alternative payment timeframe schedule the Contractor must provide a signed contract at the first (1st) of each month. If during the audit the Department confirms that Contractor is not following the payment timeline the Contractor is subject to Liquid Damages as outlined in Section 13.

The Department shall have the right to invoke against any Subcontractor any remedy set forth in this Contract, including the right to require the termination of any Subcontract, for each and every reason for which it may invoke such a remedy against the Contractor or require the termination of this Contract.

6 EDUCATION, SELECTION AND ENROLLMENT PROCESS

6.1 Enrolling Eligibles in the Contractor's Health Plan

If an eligible is enrolled into an MCO, the Department will enter the enrollment information as provided in §6.2 of this Contract. The Department will provide the Contractor notification of the Medicaid eligibles who are enrolled, re-enrolled, or disenrolled from its health plan, as specified in §6.9. The Contractor shall contact its Medicaid MCO Members as required in §8 of this Contract.

The Contractor shall not discriminate against Medicaid MCO Members on the basis of their health history, health status or need for health care services or adverse change in health status. This applies to enrollment, re-enrollment or disenrollment from the Contractor's health plan. The Contractor shall provide services to all eligible Medicaid MCO Members who enroll in or are assigned to the Contractor's health plan.

6.2 Enrollment Period

The 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) calendar days following the date of the Medicaid MCO Member's initial enrollment with an MCO. A Medicaid MCO Member shall remain in the Contractor's health plan unless the Medicaid MCO Member submits a written, electronic or oral request to disenroll or transfer to another MCO for cause or the Medicaid MCO Member becomes ineligible for Medicaid and/or MCO enrollment.

Annually, the Department will mail a re-enrollment offer to Medicaid MCO Members to determine if they wish to continue to be enrolled with the Contractor's health plan. The Medicaid MCO Member will have ninety (90) days from the date the re-enrollment packet is mailed to choose another health plan. If the Medicaid MCO Member has not chosen another health plan by the time of his/her anniversary, the Medicaid MCO Member will remain with his/her current MCO and may only be disenrolled for cause.

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 enrolled in the same MCO's health plan. Depending on the date eligibility is regained, there may be a gap in the Medicaid MCO Member's coverage. If Medicaid eligibility is regained after sixty (60) calendar days, the reinstatement of Medicaid eligibility will prompt the Department's enrollment broker to mail an enrollment packet to the beneficiary. The beneficiary may also initiate the re-enrollment process without an enrollment packet. See §6.7 for additional information on re-enrollment. The member will then have only thirty (30) days to choose another health plan without cause.

6.3 Selection or Assignment of a PCP

The Contractor shall contact the Medicaid MCO Member to assist in the selection of a PCP, if a valid PCP is not selected at the time of enrollment.

The Contractor shall inform the Medicaid MCO Member that each family member has the right to choose his/her own PCP. The Contractor may explain the advantages of selecting the same PCP for all family members, as appropriate. The Contractor or the Department shall confirm the PCP selection information in a written notice to the Medicaid MCO Member.

6.4 Enrollment of Newborns

All Newborns of Contractor's Medicaid MCO Members, where the Newborn resides in the same household as the mother, are the Contractor's responsibility. To assure continuity of care in the crucial first months of the Newborn's life, every effort shall be made by the Department to expedite enrollment of Newborns into the same MCO as the mother.

Newborn enrollment for Medicaid MCO Members will occur through the following procedures:

- 6.4.1 The Department's 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 Department's MEDS system, the newborn will be considered non-linked.
- 6.4.2 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 guardian of the Newborn.
- 6.4.3 Linked Newborns that become Medicaid eligible within the first three months of life (as determined by the monthly cutoff date) will be eligible for retroactive enrollment into a health plan. Retroactive enrollment into the Contractor's health plan will occur if the Newborn's mother was enrolled in the Contractor's health plan during the birth month. The Newborn will remain in the Contractor's health plan for the remainder of the year unless the mother changes MCO health plans during the second or third month of the Newborn's life. If the aforementioned transfer occurs, the Newborn will be transferred to the mother's MCO for the remainder of the first year. If the mother transfers out of an MCO to an MHN or to fee-for-service Medicaid, the Newborn will not be transferred out of the Contractor's health plan.
- 6.4.4 Linked Newborns who become Medicaid eligible after the first three months of life will not be enrolled retroactive to the birth month. These Newborns are eligible for enrollment in the next available assignment period. If the mother is, or will be, in an MCO in the next assignment period, the Newborn will be assigned to the same MCO as the mother, unless the mother has made an alternative plan choice for the Newborn. See the MCO Policy and Procedure Guide for additional information concerning enrollment policy.
- 6.4.5 The Contractor shall reimburse the Department for any claims that the Department pays for Core Benefits rendered to Newborns

during any month that the Contractor received a Capitation Payment for the Newborn.

6.4.6 The Contractor shall comply with S. C. Code Ann. §38-71-140 (Supp. 2000, as amended) pertaining to coverage for Newborns and children for whom adoption proceedings have been instituted or completed. The Department will be responsible for paying the required Capitation Payment only for children who are Medicaid eligible.

6.5 Medicaid MCO Member Initiated Disenrollment and Change of Managed Care Plans

A Medicaid MCO Member may request disenrollment from the Contractor's health plan as follows:

- For cause, at any time.
- Without cause, at the following times:
 - During the Member Choice Period
 - At least once every 12 months thereafter

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 shall be considered approved.

6.5.1 Medicaid MCO Member Disenrollment For Cause

A Medicaid MCO Member may request disenrollment from the Contractor's health plan for cause at any time. For cause disenrollment requests must be submitted to the Department, or its subcontractor/vendor, on the appropriate form.

The following are considered cause for disenrollment by the Medicaid MCO Member:

- The Medicaid MCO Member moves out of the Contractor's Service Area;
- The Contractor's health 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; not all related services are available within the Contractor's network; and the Medicaid MCO Member's PCP or another Provider determines that receiving the services separately would subject the Medicaid MCO Member to unnecessary risk; and
- Other reasons, including, but not limited to, poor quality of care, lack of access to Covered Services, or lack of access to Providers experienced in dealing with the Medicaid MCO Member's health care needs.

6.5.2 Medicaid MCO Member Choice Period

A Medicaid MCO Member may request disenrollment once, without cause, at any time during the ninety (90) calendar days following the date of the Medicaid MCO Member's initial enrollment. The request may be verbal, written or electronic and must be made to the Department's enrollment broker.

6.6 Contractor Initiated Medicaid MCO Member Disenrollment

The Contractor may request to disenroll a Medicaid MCO Member based upon the following reasons:

- The Contractor ceases participation in the Medicaid MCO Program or in the Medicaid MCO Member's Service Area;
- The Medicaid MCO Member dies;
- The Contractor determines the Medicaid MCO Member has Medicare coverage
- The Medicaid MCO Member is placed out of home (i.e. Intermediate Care Facility for the Mentally Retarded (ICF/MR), Psychiatric Residential Treatment Facility (PRTF));
- The Medicaid MCO Member becomes an Inmate ;
- The Medicaid MCO Member moves out of state or the Contractor's Service Area;
- The Medicaid MCO Member elects hospice;
- The Medicaid Member becomes institutionalized in a long term care facility/nursing home for more than ninety (90) continuous days;
- The Medicaid MCO Member elects Home and Community Based Waiver Programs;
- The Medicaid MCO Member becomes age 65 or older; or
- The Medicaid MCO Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the Contractor's ability to furnish services to the Medicaid MCO Member or other Medicaid MCO Members.

The Contractor's request for Medicaid MCO Member disenrollment must be made in writing to the Department using the Department's Plan Initiated Disenrollment Form in the MCO Policy and Procedure Guide and the request must state the detailed reason for the disenrollment request. The Department will determine if the Contractor has shown good cause to disenroll the Medicaid MCO Member, and the Department will give written notification to the Contractor and the Medicaid MCO Member of its decision. The Contractor and the Medicaid MCO Member shall have the right to appeal any adverse decision.

The Contractor may not request disenrollment because of an adverse change in the Medicaid MCO Member's health status, utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the Contractor's health plan seriously impairs the Contractor's ability to furnish services to either this particular Medicaid MCO Member or other Medicaid MCO Members).

If the Contractor ceases participation in the Medicaid MCO Member's Service Area or ceases participation in the Medicaid MCO Program, the Contractor shall notify the Department in accordance with the termination procedures in §13.2.10 of this Contract. The Department will notify Medicaid MCO Members and offer them the choice of another managed care plan in their service area. The Contractor shall assist the Department in transitioning Medicaid MCO Members to another managed care plan to ensure access to needed health care services. Costs related to such a transfer are addressed in Section 13 of this Contract.

6.7 Department Initiated Medicaid MCO Member Disenrollment

The Department will notify the Contractor 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 Medicaid MCO Member;
- The Medicaid MCO Member's intentional submission of fraudulent information;
- The Medicaid MCO Member becomes an Inmate;
- The Medicaid MCO Member moves out of state or the Contractor's Service Area;
- The Medicaid MCO Member elects hospice;
- The Medicaid MCO Member becomes Medicare eligible;
- The Medicaid MCO Member becomes institutionalized in a long term care facility/nursing home for more than ninety (90) days;
- The Medicaid MCO Member elects Home and Community Based Waiver Programs;
- Loss of Contractor's participation;
- The Medicaid MCO Member becomes age 65 or older;
- The Medicaid MCO Member enrolls in another MCO through third party coverage; or
- The Medicaid MCO Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the Contractor's ability to furnish services to the Medicaid MCO Member or other Medicaid MCO Members

The Contractor shall immediately notify the Department when it obtains knowledge of any Medicaid MCO Member whose enrollment should be terminated. See the MCO Policy and Procedure Guide.

In an effort to minimize the number of disenrollment due to loss of Medicaid eligibility, the Department will provide the Contractor with a monthly listing of Medicaid MCO Members who were mailed an Eligibility Redetermination/Review Form during the month. The Contractor may use this information to assist its Medicaid MCO Members in taking appropriate action to maintain Medicaid eligibility.

6.8 Notification to Contractor of Membership

The Department will notify the Contractor at specified times each month of the Medicaid eligibles that are enrolled, re-enrolled, or disenroll from the Contractor's health plan for the following month. The Contractor will

receive this notification through electronic media. See the MCO Policy and Procedure Guide for record layout.

The Department will use its best efforts to ensure that the Contractor receives timely and accurate enrollment and disenrollment information. In the event of discrepancies or unresolvable differences between the Department and the Contractor regarding enrollment, disenrollment and/or termination, Department will be responsible for taking the appropriate action for resolution.

6.9 Toll Free Telephone Number

The Department will maintain a toll free telephone number for Medicaid applicants and eligible to call and ask questions or obtain information about the enrollment process, including, but not limited to, information concerning the managed care plans available.

6.10 Tracking Slot Availability

The Contractor shall identify the maximum number of Medicaid MCO Members it is able to enroll and maintain under this Contract prior to initial enrollment of Medicaid eligible. The Contractor shall accept Medicaid MCO Members in the order in which they apply as determined by the Department up to the limits specified in the MCO Policy and Procedure Guide, Required Submissions. The Contractor agrees to provide services to Medicaid MCO Members up to the maximum enrollment limits indicated for the Contractor in the MCO Policy and Procedure Guide.

The Department reserves the right to approve or deny the maximum number of Medicaid MCO Members to be enrolled in the Contractor's health plan based on the Department's determination of the adequacy of network capacity.

On a monthly basis, and consistent with the MCO Policy and Procedure Guide, the Contractor will update its numbers for maximum enrollment by county. The Contractor shall track slot availability and notify the Department's enrollment broker when filled slots are near capacity. Upon notification, the Department or its subcontractor/vendor will not assign any other eligible to the Contractor's health plan without consulting the Contractor first.

6.11 Billing and Reconciliation

If the Contractor desires a reconciliation of the enrollment, re-enrollment, and disenrollment data received from Department, the Contractor shall be responsible for that reconciliation. In the event of discrepancies, the Contractor shall notify Department or its designee immediately of the discrepancy.

7 **MARKETING**

Marketing is defined as any activity conducted on behalf of the Contractor that explicitly or implicitly refers to the Contractor's Medicaid participation, South Carolina Medicaid MCO Program or Title XIX, and is targeted in any way toward

Medicaid Eligible for the sole purpose of providing information regarding the Contractor's health plan.

Under the South Carolina Medicaid MCO Program, all marketing to Medicaid applicants or Eligible will be performed exclusively by the Department or its designee. Marketing includes, but is not limited to direct mail advertising, door-to-door, telephonic, "cold call" marketing, social networking sites, such as Facebook and Twitter and websites. The Contractor shall not sponsor or attend any marketing activities without notifying Department. All marketing, educational materials must be approved by the Department prior to use or posting. All marketing/advertising and Medicaid MCO Member education activities or materials must comply with instructions as specified in the MCO Policy and Procedure Guide.

The Department reserves the right to limit the Contractor's marketing efforts by quantity and type, if the Contractor fails to meet the quality goals of the Department as explained in Section 12 of this Contract and the MCO Policy and Procedure Guide.

The Department may impose liquidated damages or sanctions on the Contractor if the Department determines that the Contractor distributed directly or indirectly or through any agent or independent contractor marketing materials and/or MCO enrollment forms in violation of the Department's policy or federal law.

7.1 Information Provided for Enrollment Process

The Contractor shall provide each Medicaid MCO Member with clear, accurate and truthful information about the Contractor's health plan to ensure compliance with this Contract and state and federal laws and regulations. The Contractor shall ascertain whether the Medicaid MCO Member has a PCP and if so, whether that PCP is a member of the Contractor's Provider network. The Contractor shall be responsible for developing and distributing its own Medicaid MCO Member specific marketing, educational and enrollment materials including, but not limited to, evidence of coverage, Medicaid MCO Member handbook, and other materials designed for Medicaid MCO Member education and MCO enrollment form. All written material shall be written at a grade level no higher than the fourth (4th) grade, or as determined appropriate by the Department. The Contractor shall not cause or knowingly permit the use of advertising which is untrue, misleading or deceptive. The information must include a statement that enrollment in the Contractor's health plan by a Medicaid Eligible shall be voluntary. The Contractor shall inform the Medicaid MCO Members that enrollment shall be for a period of twelve (12) months contingent upon continued Medicaid eligibility and that the Medicaid MCO Member may request disenrollment once, without cause, at any time during the ninety (90) calendar days following the date of the Medicaid MCO Member's initial enrollment with the Contractor. During marketing presentations, the Contractor must ask female Medicaid MCO Members the name of the OB/GYN doctor they are currently using. The Contractor must inform the Medicaid MCO Member whether the doctor is a member of the Contractor's Provider network. If the doctor is not in the Contractor's Provider network, the Medicaid MCO Member must be provided the Contractor's current Provider listing from which she can choose a doctor.

7.2 Marketing Plan and Materials

The Contractor shall develop and implement a marketing plan, incorporating the SCDOI marketing requirements, for participation in the South Carolina Medicaid MCO Program. The Contractor shall submit their marketing plan to the Department on July 1st every year. The Contractor shall describe the marketing activities it will undertake during the Contract period and any changes must be updated prior to implementation. The Contractor's marketing plan shall take into consideration the projected enrollment levels. The Contractor shall notify the Department of its participation in each community event designed to increase community awareness of its participation in the Medicaid MCO Program.

Enrollment activities conducted by the Contractor are specifically prohibited. Only written materials describing the Contractor's health plan, as approved by the Department, can be distributed at such events. All marketing activities shall comply with the MCO Policy and Procedure Guide and this Contract.

Materials used for the purpose of marketing to Medicaid MCO Members must be prior approved by the Department and meet the standards for marketing materials outlined in the MCO Policy and Procedure Guide. The Contractor shall ensure that where ten percent (10%) of the resident population of a county is non-English speaking and speaks a specific foreign language, materials shall be made available in that specific language to assure a reasonable chance for all potential Medicaid MCO Members to make an informed choice of health plans. The Contractor is prohibited from offering or giving any form of compensation or reward as an inducement to enroll in the Contractor's health plan.

7.3 Approval of Marketing Plan and Materials

The Contractor shall submit to the Department, or its designee, all marketing plans and written materials directed at Medicaid Eligible or potential Eligible for prior approval. These materials include but are not limited to materials produced for marketing, Medicaid MCO Member education, evidence of coverage, Medicaid MCO Member handbook and grievance procedures. Marketing materials include all types of media such as brochures, leaflets, newspapers, and magazines, and radio, television, billboard and yellow page advertisements directed at Medicaid eligible or potential eligible. Marketing materials also include any electronic mail and internet-based materials.

8 **POST ENROLLMENT PROCESS**

The post enrollment process for the Medicaid MCO Program shall be as follows:

8.1 Medicaid MCO Member Identification Card

The Contractor shall issue identification (ID) card within fourteen (14) calendar days of the Medicaid MCO Members selection of a PCP or receipt of data from the Department, whichever is later. To ensure immediate access to services, the Contractor shall instruct its Providers to

accept the Medicaid MCO Member's Medicaid ID Card as proof of enrollment in the Contractor's health plan until the Medicaid MCO Member receives his/her ID card from the Contractor. A list of required ID card information is outlined in the MCO Policy and Procedure Guide. The holder of the ID card issued by the Contractor shall be a Medicaid MCO Member or his/her guardian. If the Contractor has knowledge of any Medicaid MCO Member permitting the use of this ID card by any other person, the Contractor shall immediately report this violation to the Department. The Contractor shall also ensure that its Subcontractors/network Providers can identify Medicaid MCO Members, in a manner which will not result in discrimination against the Medicaid MCO Members, in order to provide or coordinate the provision of all Core Benefits and/or Additional Services and Out-of-Plan Services.

8.2 Member Services Availability

The Contractor shall maintain an organized, integrated Medicaid MCO Member services function operated during regular business hours to assist Medicaid MCO Members with PCP selection, to explain the Contractor's policies and procedures (access and availability of health services), to provide additional information about the PCPs and/or specialist(s), to facilitate referrals to participating specialists, and to assist in resolving service and/or medical delivery problems and Medicaid MCO Member complaints.

The Contractor shall agree to maintain a toll-free telephone number for Medicaid MCO Program Members' inquiries. The toll-free telephone number shall provide Prior Authorization/access and information on services during evenings and weekends.

8.3 Member Education

The Contractor shall educate Medicaid MCO Members regarding the appropriate utilization of services; access to Out-of-Plan Services and Emergency Services (in or out of Service Area); and the process for Prior Authorization of services. Such education shall be provided no later than fourteen (14) calendar days from the Contractor's receipt of enrollment data from the Department, or its designee, and as needed thereafter. The Contractor shall identify and educate Medicaid MCO Members who access the system inappropriately and provide continuing education as needed.

The Contractor shall be responsible for reminding pregnant Medicaid MCO Members that their Newborns will be automatically enrolled for the birth month and that the Medicaid MCO Member may choose to enroll the Newborn in another MCO's health plan after delivery by contacting South Carolina Healthy Connections Choices.

The Contractor shall ensure that where at least ten percent (10%) or more of the resident population of a county is non-English speaking and speaks a specific foreign language, materials will be made available in that specific language to assure a reasonable chance for all Medicaid MCO Members to understand how to access the Contractor's health plan and use services appropriately.

The Contractor shall have written policies and procedures for educating Medicaid MCO Members about their benefits.

The Contractor shall coordinate with the Department or its designee on Medicaid MCO Member education activities as outlined in the MCO Policy and Procedure Guide to meet the health care educational needs of the Medicaid MCO Members.

The Contractor shall not discriminate against Medicaid MCO Members on the basis of their health history, health status or need for health care services. This applies to enrollment, re-enrollment or disenrollment from the Contractor's health plan.

8.3.1 Member Handbook

The Contractor shall provide each Medicaid MCO Member assign to or selecting its health plan with a Medicaid MCO Member handbook and other written materials. The Medicaid MCO Member handbook shall be written at a reading comprehension level no higher than fourth (4th) grade, or as determined appropriate by the Department, shall contain the minimum information as outlined in the MCO Policy and Procedure Guide, and shall be approved by the Department prior to issuing it to Medicaid MCO Members. The Contractor's Medicaid MCO Member handbook must be updated as required during the term of this Contract, and the Contractor must document the changes on a change control log posted on its website.

8.4 Member's Rights and Responsibilities

The Contractor shall furnish Medicaid MCO Members with both verbal and written information about the nature and extent of their rights and responsibilities as Medicaid MCO Members of the Contractor's health plan. The rights afforded to current Medicaid MCO Members are detailed in the MCO Policy and Procedure Guide, Members' Bill of Rights. The written information shall be prepared on a reading comprehension level no higher than fourth (4th) grade, or as determined appropriate by the Department. The minimum information shall include: the Medicaid MCO Member's right to receive written information about the Contractor's health plan, including information on the structure and operation of the health plan; the network Providers/Subcontractors providing the Medicaid MCO Member's health care; information about how to obtain benefits; confidentiality of patient information; the right to file grievances or complaints about the Contractor and/or care provided; information regarding advance directives as described in 42 CFR §417.436 (2009, as amended) and 42 CFR 489, Subpart I (2009, as amended) and any information that affects the Medicaid MCO Member's enrollment into the Contractor's health plan. Information regarding advance directives shall include a description of the applicable State law (Chapter 66, Section 44) and must reflect any changes in State law as soon as possible, but no later than ninety (90) calendar days after the effective date of the change. The Contractor shall provide the Medicaid MCO Member written evidence of coverage.

The Medicaid MCO Members' responsibilities shall include, but are not limited to: informing the Contractor of the loss or theft of their ID cards; presenting their ID cards when using health care services; being familiar with the Contractor's health plan's procedures to the best of their abilities; calling or contacting the Contractor to obtain information and have questions clarified; providing participating network Providers with accurate and complete medical information; following the prescribed treatment of care recommended by the provider or letting the Provider know the reasons the treatment cannot be followed, as soon as possible; making every effort to keep any agreed upon appointments; and accessing preventive care services.

9 GRIEVANCE AND APPEAL PROCEDURES

The Contractor shall establish and maintain a procedure for the receipt and prompt internal resolution of all Medicaid MCO Member grievances and appeals in accordance with S.C. Code Ann. §38-33-110 (Supp. 2002, as amended) and 42 CFR § 438.400, et seq. The Contractor's grievance and appeals procedures and any changes thereto must be approved in writing by the Department prior to implementation and must include, at a minimum, the requirements set forth herein. The Contractor shall refer all Medicaid MCO Members who are dissatisfied in any respect with the Contractor or its Subcontractor to the Contractor's designee authorized to require corrective action. In all cases, where the Medicaid MCO Member has a grievance about treatment by the Contractor, or its Subcontractor, the Medicaid MCO Member must exhaust the Contractor's internal grievance/appeal procedures prior to accessing the State's Fair Hearing process.

9.1 General Requirements

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

9.1.2 Filing Requirements

9.1.2.1 Authority to file.

9.1.2.1.1 A Medicaid MCO Member may file a Grievance and a Contractor level Appeal, and may request a State Fair Hearing, once the Contractor's Appeals process has been exhausted.

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

9.1.2.2 Timing. The Medicaid MCO Member must be sent notice of the Contractor's action by certified mail return receipt requested and allowed at least thirty (30) calendar days from the receipt by the Medicaid MCO Member of the Contractor's notice of action to respond to the notice. Within that timeframe:

9.1.2.2.1 The Medicaid MCO Member may file an Appeal or request the Provider to file an Appeal on the Medicaid MCO Member's behalf. During the Contractor's Appeal process neither the Medicaid MCO Member nor the Provider who is acting on behalf of the Medicaid MCO Member is required to provide a written authorization.

9.1.3 Procedures.

9.1.3.1 The Medicaid MCO Member may file a Grievance with the Contractor either orally or in writing.

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

9.2 Notice of Grievance and Appeal Procedures

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

9.3 Grievance/Appeal Records and Reports

A copy of an oral Grievances log and records of disposition of written Appeals shall be retained in accordance with the provisions of S.C. Code Ann. §38-33-110 (2)(a) (Supp. 2002, as amended).

The Contractor shall provide the Department with a quarterly written report of all Grievances/Appeals filed by Medicaid MCO Members, to include: Medicaid MCO Member's name and Medicaid number; summary of Grievance and/or Appeal; date of filing; current status; resolution; and any resulting corrective action. The Contractor will be responsible for promptly forwarding, within forty-eight (48) hours, any adverse decisions to the Department for further review/action upon request by the Department or the Medicaid MCO Member. The Department may submit recommendations to the Contractor regarding the merits or suggested resolution of any Grievance/Appeal. See the MCO Policy and Procedure Guide.

9.4 Handling of Grievances and Appeals

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

9.4.1 General requirements.

In handling Grievances and Appeals, the Contractor must meet the following requirements:

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

9.4.1.2 Acknowledge receipt of each Grievance and Appeal

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

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

9.4.1.3.2 Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the State, in treating the Medicaid MCO Member's condition or disease?

9.4.1.3.2.1 An Appeal of a denial based on lack of Medically Necessary service.

9.4.1.3.2.2 A Grievance regarding denial of expedited resolution of an Appeal.

9.4.1.3.2.3 A Grievance or Appeal that involves clinical issues.

9.4.2 The process for Appeals must:

9.4.2.1 Provide that oral inquiries seeking to appeal an action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing, unless the Medicaid MCO Member or the Provider requests expedited resolution.

9.4.2.2 Provide the Medicaid MCO Member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. (The Contractor must inform the Medicaid MCO Member of the limited time available for this in the case of expedited resolution.)

9.4.2.3 Provide the Medicaid MCO Member and his or her

representative opportunity, before and during the Appeals process, to examine the Medicaid MCO Member's case file, including medical records, and any other documents and records considered during the Appeals process.

9.4.2.4 Include, as parties to the Appeal:

9.4.2.4.1 The Medicaid MCO Member and his or her representative; or

9.4.2.4.2 The legal representative of a deceased Medicaid MCO Member's estate.

9.4.3 The Contractor's staff shall be educated concerning the importance of the Grievance and Appeal procedures and the rights of the Medicaid MCO Members and Providers.

9.4.4 The appropriate individual or body within the Contractor's health plan having decision making authority as part of the Grievance/Appeal procedure shall be identified.

9.5 Notice of Action

9.5.1 Language and format requirements

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

9.5.2 Content of Notice

The notice must explain the following:

9.5.2.1 The Action the Contractor or its Subcontractor has taken or intends to take.

9.5.2.2 The reasons for the Action.

9.5.2.3 The Medicaid MCO Member's or the Provider's right to file an appeal with the Contractor.

9.5.2.4 The Medicaid MCO Member's right to request a State Fair Hearing, after the Contractor's Appeal process has been exhausted.

9.5.2.5 The procedures for exercising the rights specified in this Section 9.

9.5.2.6 The circumstances under which expedited resolution is available and how to request it.

9.5.2.7 The Medicaid MCO Member's right to have benefits continue pending resolution of the Appeal, how to request

that benefits be continued, and the circumstances under which the Medicaid MCO Member may be required to pay the costs of these services.

9.5.3 Timing of Notice

The Contractor must mail the notice within the following timeframes:

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

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

9.5.3.3 For standard service authorization decisions that deny or limit services, as expeditiously as the Medicaid MCO Member's health condition requires and within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days, if:

9.5.3.3.1 The Medicaid MCO Member, or the Provider, requests extension; or

9.5.3.3.2 The Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the Medicaid MCO Member's interest.

9.5.3.4 If the Contractor extends the timeframe in accordance with §9.6.3.3.1 or §9.6.3.3.2, it must:

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

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

9.5.3.5 For service authorization decisions not reached within the timeframes specified in §9.6.3.3 (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

9.5.3.6 For expedited service authorization decisions where a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously

jeopardize the Medicaid MCO Member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the Medicaid MCO Member's health condition requires and no later than three (3) business days after receipt of the request for service.

9.5.3.6.1 The Contractor may extend the three (3) business days' time period by up to fourteen (14) calendar days if the Medicaid MCO Member requests an extension, or if the Contractor justifies (to the Department upon request) a need for additional information and how the extension is in the Medicaid MCO Member's interest.

9.5.3.7 The Department shall conduct periodic random reviews to ensure that Medicaid MCO Members are receiving such notices in a timely manner.

9.6 Resolution and Notification

Basic Rule. The Contractor must dispose of Grievances, resolve each Appeal, and provide notice as expeditiously as the Medicaid MCO Member's health condition requires, but also within the timeframes established in §9.7.1 below.

9.6.1 Specific timeframes:

9.6.1.1 Standard Disposition of Grievances

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

9.6.1.2 Standard Resolution of Appeals

For standard resolution of an Appeal and notice to the affected parties, the timeframe is established as thirty (30) calendar days from the day the Contractor receives the Appeal. This timeframe may be extended under § 9.7.2 of this Section.

9.6.1.3 Expedited Resolution of Appeals

For expedited resolution of an Appeal and notice to affected parties, the timeframe is established as three (3) business days after the Contractor receives the appeal. This timeframe may be extended under § 9.7.2 of this Section.

9.6.2 Extension of timeframes

9.6.2.1 The Contractor may extend the timeframes from § 9.7.1 of this Section by up to fourteen (14) calendar days if:

9.6.2.1.1 The Medicaid MCO Member requests the extension; or

9.6.2.1.2 The Contractor shows (to the Department's satisfaction, upon its request) that there is need for additional information and how the delay is in the Medicaid MCO Member's interest.

9.6.2.2 Requirements Following Extension

If the Contractor extends the timeframes, it must, for any extension not requested by the Medicaid MCO Member, give the Medicaid MCO Member written notice of the reason for the delay.

9.6.3 Format of Notice

9.6.3.1 Grievances. The Department must establish the method the Contractor will use to notify a Medicaid MCO Member of the disposition of a Grievance.

9.6.3.2 Appeals

9.6.3.2.1 For all Appeals, the Contractor must provide written notice of disposition.

9.6.3.2.2 For notice of an expedited resolution, the Contractor must also make reasonable efforts to provide oral notice.

9.6.4 Content of Notice of Appeal Resolution

The written notice of the resolution must include the following:

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

9.6.4.2 For Appeals not resolved wholly in favor of the Medicaid MCO Members:

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

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

9.6.4.2.3 An explanation that the Medicaid MCO Member may be held liable for the cost of those benefits if

the hearing decision upholds the Contractor's Action.

9.6.5 Requirements for State Fair Hearings

9.6.5.1 Availability. The Contractor shall send the Contractor's notice of resolution to the Medicaid MCO Member via certified mail, return receipt requested. If the Medicaid MCO Member has exhausted the Contractor level Appeal procedures, the Medicaid MCO Member may request a State Fair Hearing related to the Contractor's resolution within thirty (30) calendar days. The thirty (30) calendar day period is counted from the date the Medicaid MCO Member receives the Contractor's notice of resolution or Contractor receives a failure of delivery notification from the return receipt requested.

9.6.5.2 Parties. The parties to the State Fair Hearing include the Contractor as well as the Medicaid MCO Member and his or her representative or the representative of a deceased Medicaid MCO Member's estate.

9.7 Expedited Resolution of Appeals

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

9.7.1 Punitive Action

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

9.7.2 Action Following Denial of a Request for Expedited Resolution

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

9.7.2.1 Transfer the Appeal to the timeframe for standard resolution in accordance with § 9.7.1.2; and

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

9.7.3 Failure to Make a Timely Decision

Appeals shall be resolved no later than the above-stated time frames and all parties shall be informed of the Contractor's

decision. If a determination is not made within the above-stated time frames, the Medicaid MCO Member's request will be deemed approved as of the date upon which a final determination should have been made.

9.8 Continuation of Benefits while the Contractor Level Appeal and the State Fair Hearing are Pending

9.8.1 Terminology. As used in this Section 9, "timely" filing means filing on or before the later of the following:

9.8.1.1 Within ten (10) calendar days of the Contractor mailing the notice of Action.

9.8.1.2 The intended effective date of the Contractor's proposed Action.

9.8.2 Continuation of Benefits

The Contractor must continue the Medicaid MCO Member's benefits if:

9.8.2.1 The Medicaid MCO Member or the Provider files the Appeal timely;

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

9.8.2.3 The services were ordered by an authorized Provider;

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

9.8.2.5 The Medicaid MCO Member requests extension of benefits.

9.8.3 Duration of Continued or Reinstated Benefits

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

9.8.3.1 The Medicaid MCO Member withdraws the Appeal.

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

9.8.3.3 A State Fair Hearing Officer issues a hearing decision adverse to the Medicaid MCO Member.

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

9.8.4 Medicaid MCO Member Responsibility for Services Furnished While the Appeal is Pending

If the final resolution of the Appeal is adverse to the Medicaid MCO Member (i.e., the Contractor's action is upheld), the Contractor may recover the cost of the services furnished to the Medicaid MCO Member while the Appeal was pending, to the extent that the services were furnished solely because of the requirements of this Section and in accordance with the policy set forth in 42 CFR § 431.230(b). The Contractor may not submit any encounters information related to the services appeal if it recoups the money from the Medicaid MCO Member.

9.9 Grievance System Information

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

9.10 Recordkeeping and Reporting Requirements

Reports of Grievances and resolutions shall be submitted to the Department as specified in §§8.4, 9 and 10.8 of this Contract. The Contractor shall not modify the Grievance procedure without the Department's prior written approval.

9.11 Effectuation of Reversed Appeal Resolutions

9.11.1 Services not furnished while the Appeal is pending

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

9.11.2 Services furnished while the appeal is pending

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

10 REPORTING REQUIREMENTS

The Contractor is responsible for complying with all of the reporting requirements established by Department. The Contractor must connect using TCP/IP protocol to a specific port using ConnectDirect software after signing a Trading Partners Agreement as required by the Department's Information Technology area.

Connectivity must be verified by the Department in writing, and the Contractor shall provide the Department with a sample of all hard copy reports prior to Contract execution for prior approval. The requirements for electronic files can be found in the Appendix 6. The Contractor shall provide the Department and any of its designees with copies of agreed upon reports generated by the Contractor concerning Medicaid MCO Members and any additional reports as requested in regard to performance under this Contract. The Department will provide the Contractor with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. All reporting periods, minimum data elements and required formats for these reports are specified in the Appendix 6. All reports shall be submitted in accordance with the schedule outlined in §13.3 of this Contract. In the event there are no instances to report, the Contractor shall submit null reports. Additional reports may be required in the Appendix 6.

The Contractor shall certify all submitted data, documents and reports to be accurate, complete and truthful. This certification shall be made by one of the following: (1) the Contractor's Chief Executive Officer (CEO); (2) the Contractor's Chief Financial Officer (CFO); or (3) an individual who has the delegated authority to sign for, and who reports directly to the CEO or CFO. The certification shall be submitted concurrently with the certified data.

10.1 Contractor's Network Providers and Subcontractors

The Contractor shall furnish to the Department or its designee a monthly report of all network Providers and Subcontractors enrolled in the Contractor's health plan, including, but not limited to, PCPs, hospitals, home health agencies, pharmacies, medical vendors, specialty or referral Providers and any other Providers which may be enrolled for purposes of providing health care services to Medicaid MCO Members under this Contract. The Contractor shall also furnish to the Department or its designee adequate copies of the PCP listing as requested by the Department. It shall be the Contractor's responsibility to assure confidentiality of the Medicaid Provider's identification number and indemnify the Department in accordance with §13.26 of this Contract. The Department is to be provided advance copies of all updates not less than ten (10) business days in advance of distribution. Any Provider no longer taking new Medicaid MCO Members must be clearly identified. Any age restrictions for a Provider must be clearly identified. The day and time of operations of the Provider must be included on all submissions. The minimum data elements and required format for this listing may be found in the MCO Policy and Procedure Guide.

For any provider not enrolled in the South Carolina Medicaid Program, the Contractor shall furnish to the Department a monthly file utilizing the requirements and required format identified in the MCO Policy and Procedure Guide. Contractor shall report quarterly Providers that are operating under attestations or have a single case agreement, Memorandum of Understanding, Memorandum of Agreement or any arrangement through which the Provider treats the Contractor's Medicaid MCO Members.

10.2 FQHC/RHC Encounter Reporting

The Contractor shall submit a quarterly report of Encounter/claims data, organized by date of service, for all contracting FQHCs and RHCs for State Plan required reconciliation purposes. See the MCO Policy and Procedure Guide and the Companion Guide for FQHC/RHC Encounter reporting specifications. The Encounter data shall be submitted no later than sixty (60) calendar days following the quarter's end.

10.3 Individual Encounter Reporting

The Contractor must submit encounter/claim data to Department for every service rendered to a member for which the Contractor either paid or denied reimbursement. Individual encounter/claim data shall be reported monthly as specified in the schedule outlined in §13.3 utilizing the requirements as specified in the MCO Policy and Procedure Guide and in the format outlined in the Companion Guide. In the event a national standardized encounter reporting format is developed, the Contractor agrees to implement this format if directed to do so by Department. The Contractor agrees, if required, to submit encounter data utilizing the HIPAA compliant transaction format and data elements and required format are identified in the MCO Policy and Procedure Guide and the Companion Guide.

For encounter data submissions, the Contractor shall submit 100% of its Encounter data. The Contractor shall not submit encounter files that are over 200,000 records in any one submission. The Contractor must submit encounters at least twice monthly with the last submission due no later than the twenty-fifth (25th) business day of the month following the month in which the claims were processed and approved/paid. The encounter submission will include encounters reflecting a zero dollar amount (\$0.00). Encounter data shall be submitted in the required format established by the Department. Each encounter data submission shall be accompanied by a statement of certification of the number of paid claims/encounters identified by date of service. The Contractor shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. All submitted data must be 100% correct no later than ninety (90) calendar days following the end of the month of submission. There is no limit on the number of times encounter data can be resubmitted within the ninety (90) calendars day period. Submissions shall be comprised of encounter records, or adjustments to previously submitted records, which the Contractor has received and processed from provider encounter or claims records of any contracted services rendered to the members.

Encounter data received from the Contractor will be enhanced and edited by standards established by the Department. In addition a summary document will also be sent with each encounter submission which identifies the number of encounters submitted and a breakdown of any errors/issues. This enhanced file and summary file will be provided to the Contractor within two (2) business days after the Contractor submits the encounter data to the Department in a format specified in the Report Companion Guide encounter/edit information.

10.4 Abortion Reporting

The Contractor shall submit a monthly report of all therapeutic abortions performed on a Medicaid MCO Member. The report shall include medical records to support each abortion performed, a copy of the completed abortion statement and a copy of the police report, if applicable. Please see the MCO Policy and Procedure Guide for the Abortion Guidelines. (This Section 10.5 is not applicable if the Contractor is operating under Section 1.8 of this Contract).

10.5 Grievance/Appeal Log Summary Reporting

In accordance with the provision in Section 9 of this Contract, the Contractor shall log grievance/appeal information regarding all active and resolved grievances/appeals on a monthly basis and submit the log to the Department quarterly. The minimum data elements and required format are identified in the MCO Policy and Procedure Guide.

10.6 Institutional Long Term Care/Nursing Home Reporting

The Contractor shall notify the Department or its designee when a Medicaid MCO Member is accepted and approved for institutionalization in a long term care facility/nursing home and again at the time the ninety (90) continuous days of placement is completed.

10.7 Disenrollment Reporting

The Contractor shall submit disenrollment requests to the Department for approval in accordance with §§6.5 & 6.6 of this Contract. The Contractor shall immediately notify the Department when it obtains knowledge of any Medicaid MCO Member whose enrollment should be terminated. See the MCO Policy and Procedure Guide for a sample form.

10.8 Quality Assessment and Performance Improvement

The Contractor will submit reports of Quality Assessment and Performance Improvement (QAPI) activities, including a quality assessment (QA) work plan, plan of correction (POC), utilization management (UM) activities and work plan, program integrity work plan and quality measures documentation in accordance with the periodicity contained in §11 of this Contract and the MCO Policy and Procedure Guide.

The Contractor shall collect information and report all HEDIS measures designated by the Department in this Contract and the MCO Policy and Procedure Guide. The Contractor should collect HEDIS measures on calendar year basis and submit this information to Department. However, the Contractor is not required to submit audited HEDIS results to Department until June 15, 2012 for the 2011 calendar year. This requirement may be adjusted if the Contractor is in the process of obtaining NCQA certification but has not completed the entire process.

10.9 Member Satisfaction Survey

The Contractor will conduct an annual Medicaid MCO Member satisfaction Survey, utilizing the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey criteria and will submit the survey results and a copy of the instrument used to the Department. The Department will coordinate with the Contractor to determine the schedule for conducting the survey and submitting the results to the Department. Should the Contractor utilize an outside vendor to perform the requirements of this Section 10.10, said vendor must have national accreditation and approval from the Department prior to conducting the survey. The Department reserves the right to add questions to the survey.

10.10 Pay for Reporting

The Contractor must comply with the reporting requirements and timelines for the quarterly Capitation Rate Calculation Sheet (CRCS) reports, as outlined in the MCO Policy and Procedure Guide.

10.11 Additional Reports

The Contractor shall prepare and submit any other reports as required and requested by the Department, any of the Department's designees, and/or CMS, that are related to the Contractor's duties and obligations under this Contract. Information the Contractor considers proprietary must be clearly identified as such by the Contractor at the time of submission.

10.12 Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid prepaid health plans (42 CFR §§455.100-455.104 (2010, as amended)). The Disclosure of Ownership and Control Interest Statement must be submitted to the Department with this Contract and resubmitted to the Department prior to each contract period or when any change in the Contractor's management, ownership or control occurs. The Contractor agrees to report any changes in ownership and disclosure information to the Department at least thirty (30) calendar days prior to the effective date of the change.

10.13 Information Related to Business Transactions

The Contractor agrees to furnish to the Department or to HHS information concerning significant business transactions as set forth in 42 CFR §455.105 (2010, as amended). Failure to comply with this requirement may result in termination of this Contract.

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

1. The ownership of any Subcontractor with whom the Contractor has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of this request; and

2. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any Subcontractor, during the five-year period ending on the date of this request. For the purpose of this Contract, "significant business transactions" means any business transaction or series of transactions during any of the fiscal year that exceed the \$25,000 or 5% of the Contractor's total operating expenses.

10.14 Information on Persons Convicted of Crimes

The Contractor agrees to furnish to the Department or HHS information concerning any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR §455.106 (2010, as amended). Failure to comply with this requirement may lead to termination of this Contract.

10.15 Errors

The Contractor agrees to prepare complete and accurate reports for submission to the Department as defined in §13.3 of this Contract and in the format described in the MCO Policy and Procedure Guide and Appendix 6. If, after preparation and submission, a Contractor error is discovered either by the Contractor or the Department, the Contractor must correct the error(s) and submit accurate reports as follows:

- (a) For Encounter submissions - in accordance with the timeframes specified in §13.3 of this Contract.
- (b) For all other reports – fifteen (15) calendar days from the date of discovery by the Contractor or date of written notification by the Department (whichever is earlier).

The Contractor's failure to respond within the above specified timeframes may result in a loss of any money due the Contractor and the assessment of liquidated damages as provided in §13.3 of this Contract.

10.16 Required Submissions

Prior to September 1, 2012, the Contractor shall submit to the Department the Required Submissions documents, as described in the MCO Policy and Procedure Guide. The Department shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the Contractor's responsibilities under this Contract. Upon approval of the Required Submissions, the Contractor shall submit a complete copy of all Required Submissions documents in a format specified in the MCO Policy and Procedure Guide. Thereafter, on July 1st of each year of this term of Contract, as extended, the Contractor shall submit, in the aforementioned format all approved Policies and Procedures including and not limited to all current boilerplate contracts during the year as well as any other administrative requirements of the Department. This information must be upload to the extranet.

10.17 Coding Requirements

The Contractor and its Subcontractors must comply with the Department's requirements when reporting data to the Department.

11 **QUALITY ASSESSMENT, MONITORING AND REPORTING**

11.1 Quality Assessment and Performance Improvement

The Contractor will establish and implement a system of Quality Assessment and Performance Improvement (QAPI) as required by 42 CFR §§438.200-438.242 and a Utilization Management (UM) program as required by 42 CFR Part 456 and detailed within the MCO Policy and Procedure Guide. The Contractor will submit, annually by December 15, its Quality Assessment Workplan, UM Workplan and Program Integrity Plan to the Department for review and approval. Any subsequent changes or revisions must be submitted to the Department for approval prior to implementation. The full scope of QAPI and UM requirements are outlined in the MCO Policy and Procedure Guide, Quality Assessment and Utilization Management Requirements.

The Contractor is required to conduct performance improvement projects as specified in the MCO Policy and Procedure Guide.

The Contractor agrees to an External Quality Review, review of Quality Assessment Committee meeting minutes and annual medical audits to ensure that it provides quality and accessible health care to Medicaid MCO Members, in accordance with standards contained in the MCO Policy and Procedure Guide and under the terms of this Contract. Such audits shall allow the Department or its duly authorized representative to review individual medical records and identify and collect management data, including, but not limited to, survey and other information concerning the use of services and the reasons for disenrollment.

It is agreed that the standards by which the Contractor will be surveyed and evaluated will be at the Department's sole discretion and approval. If deficiencies are identified, the Contractor must formulate a Plan of Correction (POC) incorporating a timetable within which it will correct deficiencies identified by such evaluations and audits. The Department must prior approve the POC and will monitor the Contractor's progress in correcting the deficiencies. See the MCO Policy and Procedure Guide.

The Contractor must attain accreditation by the National Committee for Quality Assurance (NCQA). If the Contractor is not currently accredited by NCQA, the Contractor must attain accreditation by meeting NCQA's accreditation standards by December 31, 2012. Thereafter, the Contractor must obtain the NCQA accreditation of "Excellent" in the next review period.

11.1.1 Quality Measures and HEDIS

The Contractor is required to conduct quality of care outcome studies which include quality measures for HEDIS. Measures will include all Medicaid plan measures required by the NCQA for

accreditation, in addition to measures specified in the MCO Policy and Procedure Guide. Beginning with calendar year 2011 data, HEDIS measures must be submitted in accordance with the NCQA-specified standards and auditing and submission process. The Department at its discretion may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

11.2 Quality Incentives Program

Quality incentives programs are based on the Department's fiscal year (July 1 - June 30). This Contract crosses two fiscal years and as such Year 1 incentives will begin July 1, 2012 and will expire on June 30, 2013.

In establishing the Incentive Pool for Year 1, the Department has allocated an Incentive Pool for Provider-designated Incentives and Contractor-designated Incentives. Details of these incentives and requirements can be found in Appendix 5 of the MCO Policy and Procedure Guide.

Year 2 will be July 1, 2013 through December 31, 2013. The quality incentive targets will be determined by the Department prior to fiscal year 2014. The incentive is expected to be a percentage of the total Capitation Payments eligible for the quality incentive pool.

In establishing the Incentive Pool for Year 2, the Department will allocate an incentive pool for Provider-designated Incentives and Contractor-designated Incentives. Details of these incentives and requirements will be added to the MCO Policy and Procedure.

All incentive payments will be distributed in accordance with 42 CFR 438.6 and be subject to CMS approval and federal financial participation.

11.3 Withhold for Quality Performance Measures

The Department will establish at-risk performances-based quality objectives. These at-risk performance measures will be based on the calendar year.

For Year 1 the at-risk performance measures will be from July 1, 2012 and terminate on December 31, 2012. Details of the at-risk performance measures withhold are outlined in Appendix 5 of the MCO Policy and Procedure Guide.

For Year 2 the at-risk performance measures will be from January 1, 2013 and terminate on December 31, 2013. Details of these incentives and requirements will be added to the MCO Policy and Procedure prior to January 1, 2013.

11.4 Auto-Assignment Algorithm

The Department shall update the managed care auto-assignment algorithm to direct beneficiaries to managed care health plans that have higher quality and performance measures, as reasonably determined by the Department or its designee.

11.5 Inspection, Evaluation and Audit of Records

At any time, whether announced or unannounced, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, the Department, and/or any of the designees of the above, and as often as they may deem necessary during the contract period and for a period of five (5) years from the expiration date of this Contract (including any extensions to the Contract), shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of this Contract and the MCO Policy and Procedure Guide. The Contractor shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, the Department, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with Contractor clients and employees, and do on-site reviews of all matters relating to service delivery as specified by this Contract. See the MCO Policy and Procedure Guide.

The Contractor and all of its Subcontractors 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. If any litigation, claim, or other action involving the records has 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. The Department and/or any designee will also have the right to:

- 11.5.1 Inspect and evaluate the qualifications and certification or licensure of Contractor's Subcontractors;
- 11.5.2 Evaluate, through inspection of Contractor's and its Subcontractor's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to members;
- 11.5.3 Evaluate the Contractor's performance for the purpose of determining compliance with the requirements of the Contract;
- 11.5.4 Audit and inspect any of Contractor's or its Subcontractor's records that pertain to health care or other services performed under this Contract, determine amounts payable under this Contract, or the capacity of the Contractor to bear the risk of financial losses;
- 11.5.5 Audit and verify the sources of Encounter data and any other information furnished by the Contractor in response to reporting requirements of this Contract, including data and information furnished by subcontractors;
- 11.5.6 Monitor enrollment and termination practices and ensure proper implementation of the Contractor's Grievance procedures, in

compliance with 42 CFR §§438.226-438.228 (2009, as amended). The Department and/or its designee shall have access to all information related to complaints and Grievances filed by Medicaid MCO Members.

The Contractor agrees to provide, upon request, all necessary assistance in the conduct of the evaluations, inspections, and audits. The Contractor also agrees that all statements, reports and claims, financial and otherwise, shall be certified as true, accurate, and complete, and the Contractor shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, this Contract, or the Department's policy.

11.6 Changes Resulting from Monitoring and Audit

The Contractor will be responsible for assuring corrective actions are taken when any discovery is made under Section 11.2 that the Contractor or subcontractor is not in compliance with the requirements of this Contract. The Department reserves the right to suspend enrollment in the Contractor's health plan if it is determined that quality of care is inadequate. See the MCO Policy and Procedure Guide.

In the event the Contractor fails to complete the actions required by the POC, the Contractor agrees that Department may assess the liquidated damages specified in §13.3 of this Contract. The Contractor further agrees that any liquidated damages assessed by the Department will be due and payable to the Department immediately upon notice. If payment is not made by the due date, said liquidated damages shall be withheld by Department from Contractor's future capitation payments without further notice.

11.7 Medical Records Requirements

The Contractor will require network Providers/Subcontractors to maintain up-to-date medical records at the site where medical services are provided for each Medicaid MCO Member enrolled 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. The Contractor shall ensure within its own Provider network that the Department's representatives or designees shall have immediate and complete access to all records pertaining to the health care services provided to Medicaid MCO Members. Medical record requirements are further defined in the MCO Policy and Procedure Guide.

11.8 Record Retention

All records originated or prepared in connection with Contractor'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 Contractor and its subcontractors in accordance with the terms and conditions of this Contract.

The Contractor further 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 the Department, 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 the Contractor stores records on microfilm or microfiche, Contractor hereby agrees to produce, at Contractor's expense, legible hard copy records, upon the request of state or federal authorities, within fifteen (15) calendar days of the request.

12 DEPARTMENT RESPONSIBILITIES

12.1 Department Contract Management

The Department will be responsible for the administrative oversight of the Medicaid MCO Program. As necessary and appropriate, the Department will provide clarification of the Medicaid MCO Program and Medicaid policy, regulations and procedures. The Department will be responsible for the management of this Contract. All Medicaid policy decision making or interpretations of this Contract will be made solely by the Department and are considered final. The management of this Contract will be conducted in the best interests of the Department and the Medicaid MCO Members.

Whenever the Department is required by the terms of this Contract to provide written notice to the Contractor, such notice will be signed by the Director of Department or his/her designee.

12.2 Payment of Capitated Rate

The Contractor shall be paid a Capitated Payment in accordance with the capitated rates specified in Appendix B, Capitation Rate(s) and Rate Methodology. These rates will be reviewed and adjusted at the Department's discretion. These rates shall not exceed the limits set forth in 42 CFR §438.6(c).(2011, as amended).

12.3 Immunization Data

The Contractor and its subcontracted Providers shall work with DHEC to match immunization data with Medicaid MCO Member records. The Contractor will provide the Department with the immunization data. The Contractor shall require its Subcontractors to provide immunization data on all claims.

12.4 Notification of Medicaid MCO Program Policies and Procedures

The Department will provide the Contractor with updates to appendices, information on and interpretation of all pertinent federal and state Medicaid regulations, and Medicaid MCO Program policies, procedures and guidelines affecting the provision of services under this Contract. The Contractor will submit written requests to the Department for additional clarification, interpretation or other information in a grid format specified by the Department in the MCO Policy and Procedure Guide. The Department's provision of such information does not relieve the Contractor of its obligation to keep informed of applicable federal and state laws related to its obligations under this Contract.

12.5 Provider Participation

The Contractor will within one (1) business day of receipt of such information notify the Department, in writing, of any of the Contractor's Providers or Subcontractors who have been suspended or terminated from participation in Medicare or any Medicaid program.

12.6 Quality Assessment and Monitoring Activities

The Department is responsible for monitoring the Contractor's performance to assure the Contractor is in compliance with this Contract provisions and the MCO Policy and Procedure Guide. The Department, or its designee, shall coordinate with the Contractor to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.

On at least an annual basis, the Department, or its designee, shall inspect the Contractor's facilities, as well as auditing and/or review of all records developed under this Contract including periodic medical audits, Grievances, enrollments, disenrollments, termination, utilization and all financial records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.

The Contractor shall have the right to review any of the findings and recommendations resulting from such contract monitoring and audits. However, once the Department finalizes the results of monitoring and/or auditing, the Contractor must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in liquidated damages, sanctions, enrollment restriction, marketing restrictions, change in the assignment algorithm, or termination of this Contract.

12.6.1 Fee-for-Service Reporting to MCOs

To facilitate the treatment of Medicaid MCO Members the Department will be responsible for providing the Contractor with a recent retrospective fee-for-service history on all of the Contractor's then current Medicaid MCO Members, if available. This history will contain a maximum of twenty-four (24) months from the month the Medicaid MCO Member was determined to be an Eligible.

12.6.2 Request for Plan of Correction

The Department will monitor the Contractor's quality of care outcome activities and corrective actions taken as specified in the Medicaid MCO Program Quality Assessment Plan in the MCO Policy and Procedure Guide.

The Contractor must make provisions for prompt response to any detected deficiencies or contract violations and for the development of corrective action initiatives relating to this Contract.

12.6.3 External Quality Review

The Department will perform periodic medical audits to determine whether the Contractor furnished quality and accessible health care to Medicaid MCO Members in compliance with 42 CFR §438.358 (2010, as amended). The Department may contract with an External Quality Review Organization (EQRO) to perform the periodic medical audits and external independent reviews. The MCO Policy and Procedure Guide lists the Department's external quality assessment evaluation requirements.

12.7 Marketing

The Department, and/or its designee shall have the right to approve, disapprove or require modification of all marketing plans, materials, activities, and member handbooks, provider manuals. This includes but is not limited to social network sites, electronic media (television, radio, internet, smart phones), advertisements whether print or electronic developed by the Contractor pursuant to this Contract. See § 7 of this Contract and the MCO Policy and Procedure Guide for guidance.

12.8 Grievances/Appeals

The Department shall have the right to approve, disapprove or require modification of all Grievance procedures submitted under this Contract. The Department requires the Contractor to meet and/or exceed the Medicaid MCO Program Grievance standards as outlined in §9 of this Contract.

12.9 Training

The Department will conduct Provider training and workshops on its program policies and procedures annually or more frequently if the Department deems appropriate.

12.10 Federal Fund Restrictions

The Contractor shall access the OIG electronic data bases on a monthly basis to identify whether any individuals with whom the Contractor has a relationship are prohibited from receiving Federal funds. The Contractor shall report the findings from this monthly inquiry to the Department.

13 TERMS AND CONDITIONS

The Contractor agrees to comply with all state and federal laws, regulations, and policies as they exist as of the date of this Contract or as later amended that are or may be applicable to this Contract, including those not specifically mentioned herein. Any provision of this Contract which is in conflict with federal statutes, regulations, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal policies. Such amendment of the Contract will be effective on the effective date of the statutes, regulations, or policy statements necessitating amendment, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties. The Contractor may request the Department make policy determinations required for proper performance of the services under this Contract. The Contractor shall be entitled to rely upon and act in accordance with such policy determinations when such determinations are made in writing and signed by the Director of Department.

13.1 Applicable Laws and Regulations

The Contractor agrees to comply with all applicable federal and state laws and regulations including Constitutional provisions regarding due process and equal protection under the laws including, but not limited to:

- 13.1.1 Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);
- 13.1.2 S.C. Code Ann. §38-33-10 et seq. (Supp. 2000, as amended) and 25A S.C. Code Ann. Regs. §69-22 (Supp. 2000, as amended);
- 13.1.3 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.) and 20 USC §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);
- 13.1.4 Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et seq.) and regulations issued pursuant thereto, (45 CFR Part 80), which provide that the Contractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract;
- 13.1.5 Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or applicants for employment;
- 13.1.6 Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. §794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;
- 13.1.7 The Age Discrimination Act of 1975, as amended, 42 U.S.C §6101 et seq., which prohibits discrimination on the basis of age in

programs or activities receiving or benefiting from federal financial assistance;

- 13.1.8 The Omnibus Budget Reconciliation Act of 1981, as amended, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;
- 13.1.9 The Balanced Budget Act of 1997, as amended, P.L. 105-33, and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;
- 13.1.10 The Americans with Disabilities Act, as amended, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;
- 13.1.11 Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusion of Contractors for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;
- 13.1.12 The Drug Free Workplace Acts, S.C. Code Ann. §44-107-10 et seq. (Supp. 2000, as amended), and the Federal Drug Free Workplace Act of 1988 as set forth in 45 CFR Part 82 (2008, as amended); and
- 13.1.13 Title IX of the Education Amendments of 1972 regarding education programs and activities.

13.2 Termination

This Contract shall be subject to the termination provisions as provided herein. The Department or its designee will give the Contractor written notice that the Contractor has failed to perform its contractual undertakings and may, at the discretion of the Department, give the Contractor a specific time period in which to correct the deficiencies before the actual termination will occur. If the Department determines that the Contractor has satisfactorily implemented corrective action, a notice of termination will not be issued. If the Department determines that the Contractor has not satisfactorily corrected the problem(s), the Department will provide the Contractor with a written Intent to Terminate the Contract between the Department and the Contractor. The Intent to Terminate will include the date, time and location of a fair hearing before the Department Division of Appeals and Hearings. In the event of such termination, it is agreed that neither party shall be relieved from any financial obligations each may owe to the other. The Contractor will assume the cost and responsibility for informing all affected Medicaid MCO Members of the the Contractor's termination. Medicaid MCO Members shall be allowed to disenroll in accordance with the Department's time frame without cause. Regardless from the reason for termination both parties understand the contract will terminate on the last day of the month of termination.

13.2.1 Termination Under Mutual Agreement

Under mutual agreement, the Department and the Contractor may terminate this Contract for any reason in the best interest of the

Department and the Contractor. Both parties will sign a notice of termination which shall include, the date of termination, conditions of termination, and extent to which performance of work under this Contract is terminated. The Contractor will assume all incremental cost or charges associated with the termination.

13.2.2 Termination by Department for Breach

In the event that the Department determines that the Contractor, or any of the Contractor's Subcontractors, fails to perform its contracted duties and responsibilities in a timely and proper manner, or if the Contractor shall violate any of the terms of this Contract, the Department may terminate this Contract upon thirty (30) calendar days written notice to the Contractor. Such notice will specify the manner in which the Contractor or its Subcontractor(s) has failed to perform its contractual responsibilities. If the Department determines that the Contractor and/or its Subcontractor(s) has satisfactorily implemented corrective action within the thirty (30) calendar day notice period, the notice of termination may be withdrawn at the discretion of the Department.

The Department may terminate this Contract immediately if it is determined that actions by the Contractor or its Subcontractor(s) pose a serious threat to the health or safety of Medicaid MCO Members enrolled in the Contractor's health plan.

The Contractor will not be paid for any outstanding monies due. . If damages exceed monies due, collection can be made from the Contractor's Fidelity Bond, Errors and Omissions Insurance, or any insurance policy or policies required under this Contract or Contractor may pay any sums directly without a bond or insurance claim. The rights and remedies of the Department provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

13.2.3 Termination for Unavailability of Funds

In the event that federal and/or state funds to finance this Contract become unavailable after the effective date of this Contract, or prior to the anticipated expiration date of this Contract, the Department may terminate this Contract without penalty. This notification will be made in writing. Availability of funds shall be determined solely by the Department.

13.2.4 Termination for Contractor Insolvency, Bankruptcy, Instability of Funds

The Contractor's insolvency or the filing of a petition in bankruptcy by or against the Contractor shall constitute grounds for termination of this Contract for cause. If the SCDOI and/or the Department determine the Contractor has become financially unstable and/or the Contractor's license is revoked, the Department will

immediately terminate this Contract upon written notice to the Contractor effective at the close of business on the date specified.

13.2.5 Termination by the Contractor

The Contractor shall give the Department written notice of Intent to Terminate this Contract one hundred twenty (120) calendar days prior to the Contractor's intended last date of operation which date shall be the last day of the month of termination. Such written notice may be either hand-delivered to the Department or may be mailed by certified mail, return receipt requested. The one hundred twenty (120) calendar days' written notice shall specify the last date of operation, such date being at least one hundred twenty (120) calendar days, after the date when the Department receives the notice of termination. The Contractor shall comply with all terms and conditions stipulated in this Contract during the termination period. Any cost or charges incurred by the Department or its enrollment broker related to the Contractor's Intent to Terminate will be the responsibility of the Contractor.

13.2.6 Termination for Loss of Licensure or Certification

In the event that the Contractor loses its license issued by SCDOL or the appropriate licensing agency to operate or practice in South Carolina, this Contract shall terminate as of the date of delicensure. Further, should the Contractor lose its certification to participate in the Title XVIII and/or Title XIX program, this Contract shall terminate as of the date of such decertification. Any costs or charges incurred by the Department, its enrollment broker, or Providers as a result of such a termination will be paid by the Contractor.

13.2.7 Termination for Noncompliance with the Drug Free Workplace Act

In accordance with S.C. Code Ann §44-107-60 (Supp. 2000, as amended), this Contract is subject to immediate termination, suspension of payment, or both if the Contractor fails to comply with the terms of the Drug Free Workplace Act. Any costs or charges incurred by the Department, its enrollment broker, or Providers as a result of such a termination will be paid by the Contractor.

13.2.8 Termination for Actions of Owners/Managers

The Contractor is subject to termination, unless the Contractor can demonstrate changes of ownership or control, when:

1. A person with a direct or indirect ownership interest in the Contractor
 - a. Has been convicted of a criminal offense under §§1128(a), 1128(b)(1), or 1128(b)(3) of the Social Security Act, in accordance with 42 CFR §1002.203;

- b. Has had civil monetary penalties or assessments imposed under § 1128A of the Act; or
- c. Has been excluded from participation in Medicare or any state health care program; and
- d. Has a direct or indirect ownership interest or any combination therefore of 5% or more, is an officer if the Contractor is organized as a corporation or a partner, if it is organized as a partnership, or is an agent or a managing employee.

2. The Contractor has a direct or indirect substantial contractual relationship with an excluded individual or entity. "Substantial contractual relationship" is defined as any direct or indirect business transactions that amounts in a single fiscal year to more than \$25,000 or 5% of the Contractor's total operating expenses, whichever is less.

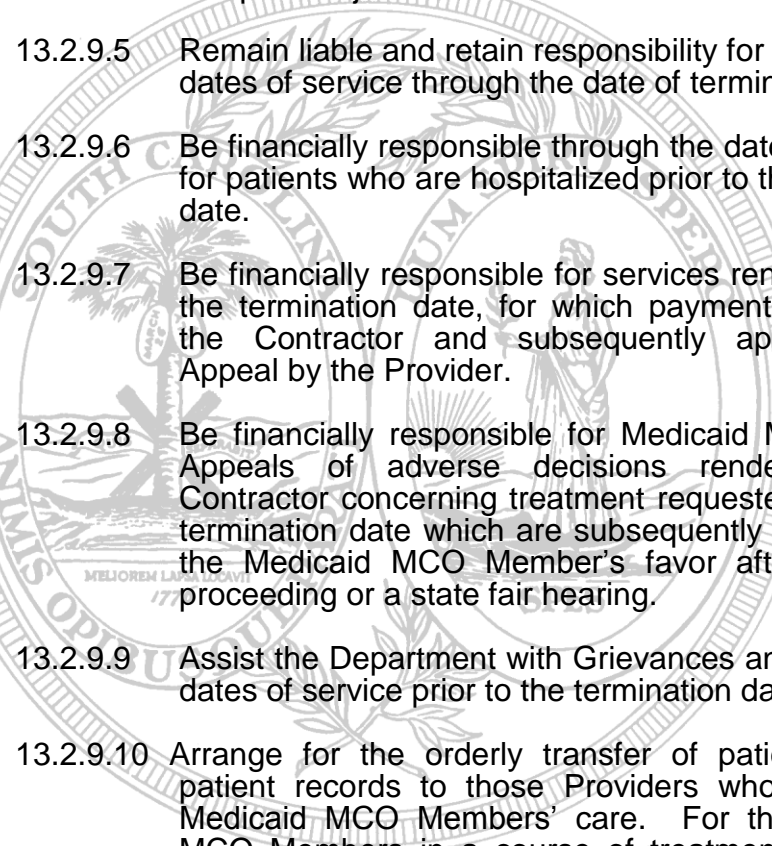
13.2.9 Procedures Related to Termination

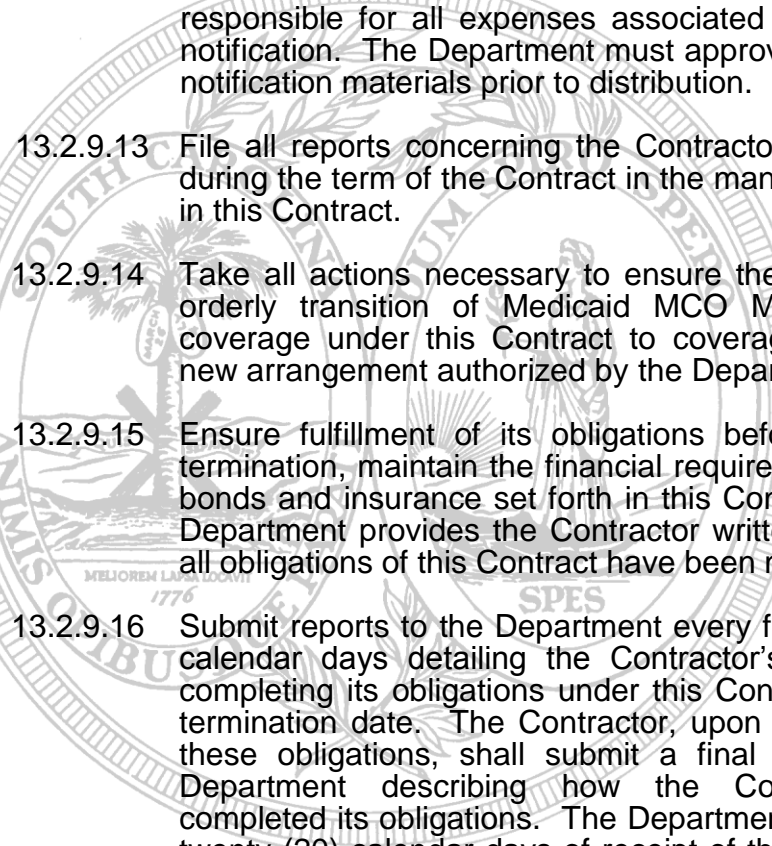
Subject to the provisions stated herein, after the Intent to Terminate has been submitted (whether related to one part of the Contractor's Service Area or this entire Contract), the Contractor shall:

13.2.9.1 Continue to provide services under the Contract, until the effective date of the termination;

13.2.9.2 Immediately terminate all marketing procedures and Subcontracts related to marketing;

13.2.9.3 Within ten (10) business days of the Contractor's written notification to Department of its Intent to Terminate this Contract, submit a termination plan to the Department for review and approval. The format for termination is outlined in the MCO Policy and Procedures Guide. The Contractor shall make revisions to the termination plan as necessary or as required by the Department and will resubmit the plan to Department for approval after each revision. Failure to submit a termination plan within ten (10) business days of written notification to the Department of termination or failure to timely resubmit the termination plan after revisions may, in the Department's discretion, result in a delay of the Contractor's planned termination date. Failure to submit a termination plan in the time specified in this provision shall result in a withhold of twenty-five percent (25%) of the Contractor's monthly Capitation Payment. These funds will be withheld by the Department and at its discretion, held until the Department receives and approves the termination plan.

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- The seal of the State of South Carolina is visible in the background, featuring a palmetto tree, a ship, and the motto 'MELIOREM LIBERTATEM SEQUITUR'.
- 13.2.9.4 Maintain claims processing functions as necessary for a minimum of twelve (12) months (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims.
- 13.2.9.5 Remain liable and retain responsibility for all claims with dates of service through the date of termination.
- 13.2.9.6 Be financially responsible through the date of discharge for patients who are hospitalized prior to the termination date.
- 13.2.9.7 Be financially responsible for services rendered prior to the termination date, for which payment is denied by the Contractor and subsequently approved upon Appeal by the Provider.
- 13.2.9.8 Be financially responsible for Medicaid MCO Member Appeals of adverse decisions rendered by the Contractor concerning treatment requested prior to the termination date which are subsequently determined in the Medicaid MCO Member's favor after an appeal proceeding or a state fair hearing.
- 13.2.9.9 Assist the Department with Grievances and Appeals for dates of service prior to the termination date.
- 13.2.9.10 Arrange for the orderly transfer of patient care and patient records to those Providers who will assume Medicaid MCO Members' care. For those Medicaid MCO Members in a course of treatment for which a change of Providers could be harmful, the Contractor must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged.
- 13.2.9.11 Notify all Medicaid MCO Members in writing about the termination of this Contract and the process by which Medicaid MCO Members will continue to receive medical care at least sixty (60) calendar days in advance of the effective date of termination. The Contractor will be responsible for all charges or costs associated with Medicaid MCO Member notification. The Department must approve all Medicaid MCO Member notification materials prior to distribution. Such notice must include a description of alternatives available for obtaining services after termination of this Contract.

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- 13.2.9.12 Terminate all subcontracts with all health care providers to correspond with the termination of this Contract at least sixty (60) calendar days in advance of the effective date of termination. The Contractor will be responsible for all expenses associated with Provider notification. The Department must approve all Provider notification materials prior to distribution.
- 13.2.9.13 File all reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract.
- 13.2.9.14 Take all actions necessary to ensure the efficient and orderly transition of Medicaid MCO Members from coverage under this Contract to coverage under any new arrangement authorized by the Department.
- 13.2.9.15 Ensure fulfillment of its obligations before and after termination, maintain the financial requirements, fidelity bonds and insurance set forth in this Contract until the Department provides the Contractor written notice that all obligations of this Contract have been met.
- 13.2.9.16 Submit reports to the Department every fourteen (14) calendar days detailing the Contractor's progress in completing its obligations under this Contract after the termination date. The Contractor, upon completion of these obligations, shall submit a final report to the Department describing how the Contractor has completed its obligations. The Department shall, within twenty (20) calendar days of receipt of this final report, advise in writing whether it agrees that the Contractor has met its obligations. If the Department does not agree, then the Contractor shall complete the necessary tasks and submit a revised final report. This process shall continue until the Department approves the final report.
- 13.2.9.17 Take whatever other actions are required by the Department to complete this transition.
- 13.2.9.18 Be responsible for all financial costs associated with its termination, including, but not limited to costs associated with changes to the enrollment broker's website, computer system, mailings, the Department and telephonic communications by the enrollment broker to the Contractor's Medicaid MCO Members regarding their choice period after the termination effective date and changes to any of the above-listed areas regarding information provided to all Medicaid MCO Members.
- 13.2.9.19 If applicable, assign to the Department in the manner and extent directed by the Department all the rights,

title and interest of the Contractor for the performance of the subcontracts as needed. In this case the Department shall have the right, in its discretion, to resolve or pay any of the claims arising out of the termination of such subcontracts. The Contractor shall supply all information necessary for the reimbursement of any outstanding Medicaid claims.

13.2.9.20 Complete the performance of such part of the Contract which shall have not been terminated under the Intent to Terminate.

13.2.9.21 Take such action as may be necessary, or as the Department may direct, for the protection of property related to this Contract which is in possession of the Contractor in which the Department has or may acquire an interest.

13.2.9.22 In the event the Contract is terminated by the Department, continue to serve or arrange for provision of services to the Medicaid MCO Members of the Contractor until the effective date of termination. During this transition period, the Department shall continue to pay the applicable Capitation Payment. Medicaid MCO Members shall be given written notice of the State's intent to terminate this Contract and shall be allowed to disenroll immediately without cause

13.2.9.23 Provide all necessary assistance to the Department in transitioning Medicaid MCO Members out of the Contractor's health plan to the extent specified in the notice of termination. Such assistance shall include, but not be limited to, the forwarding of all medical or financial records related to the Contractor's activities undertaken pursuant to this Contract; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized, and pregnant Medicaid MCO Members in their last four (4) weeks of pregnancy.

The transitioning of records, whether medical or financial, related to the Contractor's activities undertaken pursuant to this Contract shall be in a form usable by the Department or any party acting on behalf of the Department and shall be provided at no expense to the Department or another contractor acting on behalf of Department.

13.2.9.24 Promptly supply all information necessary to the Department or its designee for reimbursement of any outstanding claims at the time of termination.

Any payments due under the terms of this Contract may be withheld until the Department receives from the

Contractor all written and properly executed documents and the Contractor complies with all requests of the Department related to this Contract.

13.2.10 Once the Department receives the notice of termination, the Department shall:

13.2.10.1 Stop auto-assignment and enrollment of Medicaid MCO Members to the Contractor's health plan as of the date written notification of termination is received by the Department.

13.2.10.2 Review, revise and approve the Contractor's termination plan and final reports.

13.2.10.3 Review, revise and approve all correspondence to the Contractor's Medicaid MCO Members and Providers prior to distribution.

13.2.10.4 Cease all new enrollments in the Contractor's plan at such time as determined by Department. This decision shall be at the sole discretion of Department.

Any of the above-stated requirements may be waived or altered upon written request by the Contractor and written approval by the Department.

13.2.11 Effect of Termination on Business Associate's HIPAA Privacy Requirements

13.2.11.1 Except as provided in §13.2.11.2 below, upon termination of this Contract, for any reason, the Contractor shall return or destroy all Protected Health Information received from C the Department, or created or received by the Contractor on behalf of the Department. This provision shall apply to Protected Health Information that is in the possession of Subcontractors or agents of the Contractor. The Contractor shall retain no copies of the Protected Health Information.

13.2.11.2 In the event that the Contractor determines that returning or destroying the Protected Health Information is infeasible, the Contractor shall provide to the Contractor notification of the conditions that make return or destruction infeasible. Upon a mutual determination that return or destruction of Protected Health Information is infeasible, the Contractor shall extend the protections of this Contract to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as the Contractor maintains such Protected Health Information.

13.3 Forfeiture of Withhold Funds and Refund of Incentives Funds

Regardless of which party initiates the termination of this Contract, the Contractor understands and agrees that should a termination occur, the Contractor will forfeit any and all withhold funds for the remainder of the calendar year in which the termination occurs.

Additionally, upon termination of this Contract, the Contractor will refund to the Department any and all incentive money paid to the Contractor for the calendar year of the termination. The Contractor shall be solely responsible for the refund and shall not seek or attempt to collect any part of the incentive from any Providers to whom Contractor had previously paid a portion of the incentive.

13.4 Liquidated Damages for Failure to Meet Contract Requirements

The Department and the Contractor agree that in the event of the Contractor's failure to meet the requirements provided in this Contract and/or all documents incorporated herein, damage will be sustained by the Department and the actual damages which the Department will sustain in the event of and by reason of such failure are uncertain, and extremely difficult and impractical to ascertain and determine. The parties therefore agree that the Contractor shall pay the Department liquidated damages in the fixed amounts stated below; provided however, that if it is finally determined that the Contractor would have been able to meet the Contract requirements listed below but for the Department's failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting directly therefrom.

The Department may impose liquidated damages upon the Contractor when it fails to timely and accurately submit any reports whether it is outlined or required under this Contract, the MCO Policy and Procedure Guide and/or Companion Guide or a special report request by the Department.

For each day that a deliverable is late, incorrect, or deficient, the Contractor shall be liable to the Department for liquidated damages in the amount of One Thousand, Five Hundred Dollars (\$1,500.00) per calendar day, per file, report, encounter data submissions or other deliverable. With the exception of encounter data submissions, the Department shall utilize the following guidelines to determine whether a report is correct and complete: (1) The report must contain 100% of the Contractor's data; (2) 99% of the required items for the report must be completed; and (3) 99.5% of the data for the report must be accurate as determined by edit specifications/review guidelines set forth by Department.

Liquidated damages for late reports or deliverables shall begin on the first day after the Due Date outlined herein. Liquidated damages for incorrect reports or deficient deliverables shall begin on the sixteenth (16th) day after the date on the written notice provided by the Department to the Contractor that the report remains incorrect or the deliverables remain deficient. For the purposes of determining liquidated damages in accordance with this Section, reports or deliverables are due in accordance with the schedule below. All reports are due by noon (12 ET)

on the date it is due. Should any Date Due be a weekend day or holiday, the Date Due shall be the Department's business day prior to weekend or holiday.

Deliverables

Date Due

Daily Reports	Within two (2) business days.
Weekly Reports	Wednesday of the following week.
Monthly Reports	No later than the 15th of the following month
Quarterly Reports (non-encounter reports)	30th of the following month.
Annual Reports	Ninety (90) calendar days after the end of the year.
On Request/Additional Reports	Within three (3) business days from the date of request unless otherwise specified by the Department.
Encounter data – initial submission	(Weekly) Twenty-five (25) calendar days after the end of the month in which it was paid
Encounter data – 100% accurate Submission	Ninety (90) calendar days after the date of initial submission
County Network Submissions	Three (3) business days after request
Special Report	Three to four calendar days after request

Other liquidated damages related to certain provisions of this contract shall be as outlined below.

Contract Requirement

Liquidated Damages

Employment of licensed personnel	\$500.00 per calendar day for each day that personnel are not licensed as required by applicable state and federal laws and/or regulations. (See also §3.1.2 of this Contract).
Failure to complete corrective action as described in §§11 and 13.7	\$1500.00 per calendar day for each day the corrective action is not completed in accordance with

the timeline established in the Plan of Correction.

Late, incorrect or deficient reports, Including HEDIS reports, Encounter data initial submission, Network County Submission, CRCS Reports, FQHC/RHC Wrap report \$1500.00 per calendar day per file or report

Encounter Data – failure to meet 100% accurate submission deadline as set forth in §10.4 \$1500.00 per calendar day

Inadequate Networks as determined under Section 4 \$5,000 per calendar day

It is further agreed by the Department and the Contractor that any liquidated damages assessed by Department shall be due and payable to Department within thirty (30) calendar days after the Contractor's receipt of their notice of assessment. If payment is not made by the due date, said liquidated damages shall be withheld from future Capitation Payments by the Department without further notice. It is agreed by the Department and the Contractor that the collection of liquidated damages by the Department shall be made without regard to any appeal rights the Contractor may have pursuant to this Contract. However, in the event an appeal by the Contractor results in a decision in favor of the Contractor, any such funds withheld by the Department will be returned to the Contractor less any cost incurred by the Department.

Whenever liquidated damages for a single occurrence exceed \$2,500.00, the Contractor's staff will meet with the Department's staff to discuss the causes of the occurrence and to negotiate a plan for corrective action. The corrective action plan must include a date certain for correction of the problems that led to the occurrence along with interim milestones to be achieved, the criteria for determining that a milestone has been achieved, reporting objectives and schedule, staffing commitment and sufficiently detailed description for the Department to determine the appropriateness and effectiveness of the plan of correction. Issues that are not substantially corrected by the dates agreed upon in the plan of correction will result in the original schedule of damages will be reinstated, including collection of damages for the corrective action period, and liquidated damages will continue until satisfactory correction of the occurrence, as determined by the Department, has been made.

Whenever the Department determines, based on identified facts and documentation, that the Contractor is failing to meet material obligations and performance standards described in this Contract, it may suspend the Contractor's right to enroll new Medicaid MCO Members and impose any other sanctions and/or liquidated damages in accordance with §13.5. The Department, when exercising this option, shall notify the Contractor in writing of its intent to suspend new enrollment. The suspension period may be for any length of time specified by the Department, or may be indefinite. The Department also may notify Medicaid MCO Members of

the Contractor's non-performance and permit these Medicaid MCO Members to transfer to another health plan following the implementation of suspension.

13.5 Use of Data

The Department shall have unlimited rights to use, disclose, or duplicate, for any purpose, all information and data developed, derived, documented, or furnished by the Contractor resulting from this Contract.

The Contractor shall not use any encounter or claims information/data it receives from The Department or any other source to subtract from the number of services the new Medicaid MCO Member is entitled to receive when they transfer from one MCO to another MCO (i.e. Medicaid MCO Member had used 30 units of therapy out 75 units from MCO A and then Medicaid MCO Member transferred to MCO B, the Medicaid MCO Member would be entitled to 75 units of therapy from MCO B)

13.6 Sanctions

If the Department determines that the Contractor has violated any provision of this Contract, or the applicable statutes or rules governing Medicaid prepaid health plans, the Department may impose sanctions against the Contractor. The Department shall notify the Contractor and CMS in writing of its intent to impose sanctions and explain the Contractor's due process rights. Sanctions shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u-2) and 42 CFR §§438.700-730 (2009, as amended) and may include any of the following:

- 13.6.1 Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. This violation may result in recoupment of the capitated payment;
- 13.6.2 Suspension of all marketing activities permitted under this Contract;
- 13.6.3 Imposition of a fine of up to Twenty-five Thousand Dollars (\$25,000.00) for each marketing/enrollment violation, in connection with any one audit or investigation;
- 13.6.4 Termination pursuant to §13.2.2 of this Contract;
- 13.6.5 Non-renewal of the Contract pursuant to §13.7 of this Contract;
- 13.6.6 Suspension of auto-enrollment;
- 13.6.7 Appointment of temporary management in accordance with §1932(e)(2)(B) of SSA (42 U.S.C. 1396u-2) (2001, as amended) and 42 CFR §438.702. If the State finds that the MCO has repeatedly failed to meet substantive requirements in §1903(m) or §1932 of the Social Security Act (42 USC 1396u-2), the State must impose temporary management, grant members the right to

terminate enrollment without cause and notify the affected members of their right to terminate enrollment;

- 13.6.8 Civil money penalties in accordance with §1932 of the Social Security Act (42USC 1396u-2);
- 13.6.9 Withholding of a portion or all of the Contractor's Capitation Payment;
- 13.6.10 Permitting individuals enrolled in the Contractor's plan to disenroll without cause. Department may suspend or default all enrollment of Medicaid MCO Members after the date the Secretary or Department notifies the Contractor of an occurrence under §1903(m) or § 1932(e).of the Social Security Act;
- 13.6.11 Terminating the Contract if the Contractor has failed to meet the requirements of sections 1903(m), 1905(t)(3) or 1932(e) of the Social Security Act and offer the Contractor's Medicaid MCO Members an opportunity to enroll with other Contractors to allow Medicaid MCO Members to receive medical assistance under the South Carolina State Plan for Medical Assistance. The Department shall provide the Contractor a hearing before the Department's Division of Appeals and Hearings before termination occurs. The Department will notify the Medicaid MCO Members enrolled in the Contractor's health plan of the hearing and allow the Medicaid MCO Members to disenroll, if they choose, without cause;
- 13.6.12 Imposition of sanctions pursuant to §1932(e)(B) of the Social Security Act if the Contractor does not provide abortion services as provided under the Contract at §4;
- 13.6.13 Imposition of a fine of up to Twenty-five Thousand Dollars (\$25,000) for each occurrence of the Contractor's failure to substantially provide Medically Necessary items and services that are required to be provided to a Medicaid MCO Member covered under the Contract;
- 13.6.14 Imposition of a fine of up to Fifteen Thousand Dollars (\$15,000) per individual not enrolled and up to a total of One Hundred Thousand Dollars (\$100,000) per each occurrence, when the Contractor acts to discriminate among Medicaid MCO Members on the basis of their health status or their requirements for health care services. Such discrimination includes, but is not limited to, expulsion or refusal to re-enroll an individual, except as permitted by Title XIX, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services;
- 13.6.15 Imposition of a fine as high as double the excess amount charged to the Medicaid MCO Members by the Contractor for premiums or charges in excess of the premiums or charges permitted under Title XIX.

13.6.16 Imposition of sanctions as outlined in the MCO Policy and Procedure Guide if the Contractor fails to comply with the Physician Incentive Plan requirements.

13.6.17 Imposition of sanctions as outlined above if the Contractor misrepresents or falsifies information that it furnishes to CMS, to the State or to a Medicaid MCO Member, potential Medicaid MCO Member or Provider.

Unless the duration of a sanction is specified, a sanction will remain in effect until the Department is satisfied that the basis for imposing the sanction has been corrected. The Department will notify CMS when a sanction has been lifted.

13.7 Non-Renewal

This Contract shall be renewed only upon mutual consent of the parties. Either party may decline to renew the Contract for any reason. The parties expressly agree there is no property right in this Contract.

13.8 Plan of Correction Required (Contract Non-Compliance)

The Contractor and its Subcontractors shall comply with all requirements of this Contract. In the event the Department or its designee finds that the Contractor and/or its Subcontractors failed to comply with any requirements of this Contract, the Contractor shall be required to submit a plan of correction to the Department outlining the steps it will take to correct any deficiencies and/or non-compliance issues identified by Department in the Notice of Corrective Action along with interim milestones to be achieved, the criteria for determining that a milestone has been achieved, reporting objectives and schedule, staffing commitment and sufficiently detailed description for the Department to determine the appropriateness and effectiveness of the plan of correction. The Department shall have final approval of the Contractor's plan of correction. The Department will provide written notification to a Contractor which it places under a Corrective Action Plan (CAP). Further, to ensure transparency of operations, the Department will make a public announcement when it places the Contractor under a CAP. The announcement will, at a minimum, be made via Provider Bulletin, media release and/or publication on the Department's web site.

The Contractor's plan of correction shall be submitted to Department within the time frame specified in the Notice of Corrective Action. The Contractor and/or its Subcontractor(s) shall implement the corrective actions as approved by the Department and shall be in compliance with the Contract requirements noted within the time frame specified in the Notice of Corrective Action. The Contractor and/or its Subcontractors shall be available and cooperate with the Department and/or its designee as needed in implementing the approved corrective actions.

Failure of the Contractor and/or its subcontractor(s) to implement and follow the plan of correction as approved by the Department shall subject

the Contractor to the actions, stated in §§13.2, 13.3 and 13.5 including all subsections of this Contract.

13.9 Inspection of Records

The Contractor shall make all program and financial records and service delivery sites open to the HHS, the Department, GAO, the State Auditor's Office, the Office of the Attorney General, the Comptroller General, or their designee. The HHS, the Department, GAO, the State Auditor's Office, the Office of the Attorney General, the Comptroller General and/or their designees shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with Contractor clients and employees, and do on-site reviews of all matters relating to service delivery as specified by this Contract.

13.10 Non-Waiver of Breach

The failure of the Department at any time to require performance by the Contractor of any provision of this Contract, or the continued payment of the Contractor by the Department, shall in no way affect the right of Department to enforce any provision of this Contract; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself. No covenant, condition, duty, obligation, or undertaking contained in or made a part of this Contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable.

Waiver of any breach of any term or condition in this Contract shall not be deemed a waiver of any prior or subsequent breach. No term or condition of this Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the parties hereto.

13.11 Non-Assignability

No assignment or transfer of this Contract or of any rights hereunder by the Contractor shall be valid without the prior written consent of the Department.

13.12 Legal Services

No attorney-at-law shall be engaged through use of any funds provided by the Department pursuant to the terms of this Contract. Further, with the exception of attorney's fees awarded in accordance with S.C. Code Ann. §15-77-300 (2000, as amended), the Department shall under no circumstances become obligated to pay an attorney's fee or the costs of legal action to the Contractor. This covenant and condition shall apply to any and all suits, legal actions, and judicial appeals of whatever kind or nature to which the Contractor is a party.

13.13 Attorney's Fees

In the event that the Department shall bring suit or action to compel performance of or to recover for any breach of any stipulation, covenant, or condition of this Contract, the Contractor shall and will pay to the

Department such attorney's fees as the court may adjudge reasonable in addition to the amount of judgment and costs.

13.14 Independent Contractor

It is expressly agreed that the Contractor and any Subcontractors and agents, officers, and employees of the Contractor or any Subcontractors in the performance of this Contract shall act in an independent capacity and not as officers and employees of the Department or the State of South Carolina. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any Subcontractor and the Department and the State of South Carolina.

13.15 Governing Law and Place of Suit

It is mutually understood and agreed that this Contract shall be governed by the laws of the State of South Carolina both as to interpretation and performance. Any action at law, suit in equity, or judicial proceeding for the enforcement of this Contract or any provision thereof shall be instituted only in the courts of the State of South Carolina.

13.16 Severability

If any provision of this Contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the Department and the Contractor shall be relieved of all obligations arising under such provision. If the remainder of this Contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed. In addition, if the laws or regulations governing this Contract should be amended or judicially interpreted as to render the fulfillment of the Contract impossible or economically infeasible, both the Department and the Contractor will be discharged from further obligations created under the terms of the Contract. To this end, the terms and conditions defined in this Contract can be declared severable.

13.17 Copyrights

If any copyrightable material is developed in the course of or under this Contract, the Department shall have a royalty free, non-exclusive, and irrevocable right to reproduce, publish, or otherwise use the work for Department purposes.

13.18 Subsequent Conditions

The Contractor shall comply with all requirements of this Contract and the Department shall have no obligation to enroll any Medicaid MCO Members into the Contractor's health plan until such time as all of said requirements have been met.

13.19 Incorporation of Schedules/Appendices

All schedules/appendices referred to in this Contract are attached hereto, are expressly made a part hereof, and are incorporated as if fully set forth herein.

13.20 Titles

All titles used herein are for the purpose of clarification and shall not be construed to infer a contractual construction of language.

13.21 Safeguarding Information

The Contractor shall establish written safeguards which restrict the use and disclosure of information concerning Medicaid MCO Members or potential members to purposes directly connected with the performance of this Contract. The Contractor's written safeguards shall:

- 13.21.1 Be at least as restrictive as those imposed by 42 CFR Part 431, Subpart F (2009, as amended) and 27 S.C. Code Ann. Regs. §126-170 et seq. (Supp. 2009, as amended);
- 13.21.2 State that, in the event of a conflict between the Contractor's written safeguard standards and any other state or federal confidentiality statute or regulation, the Contractor shall apply the stricter standard;
- 13.21.3 Require the written consent of the Medicaid MCO Member or potential member before disclosure of information about him or her, except in those instances where state or federal statutes or regulations require disclosure or allow disclosure with the consent of the Medicaid MCO Member or potential Medicaid MCO Member;
- 13.21.4 Only allow the release of statistical or aggregate data that has been de-identified in accordance with federal regulations at 45 CFR §164.514 and which cannot be traced back to particular individuals; and
- 13.21.5 Specify appropriate personnel actions to sanction violators.

13.22 Release of Records

The Contractor shall release medical records of Medicaid MCO Members, as may be authorized by the member, or as may be directed by authorized personnel of the Department, appropriate agencies of the State of South Carolina, or the United States Government. Release of medical records shall be consistent with the provisions of confidentiality as expressed in this Contract.

13.23 Fraudulent Activity

The Contractor shall report to the Department any cases of suspected Medicaid fraud or abuse by its Medicaid MCO members, employees, or Subcontractors. The Contractor shall report such suspected fraud or abuse in writing as soon as practicable after discovering suspected incidents. The Contractor shall report the following fraud and abuse information to the Department:

- (a) The number of complaints of fraud and abuse made to the Contractor that warrant preliminary investigation.
- (b) For each case of suspected Provider fraud and abuse that warrants a full investigation:
 - (1) the Provider's name and number
 - (2) the source of the complaint
 - (3) the type of Provider
 - (4) the nature of the complaint
 - (5) the approximate range of dollars involved
 - (6) the legal and administrative disposition of the case

The Contractor shall adhere to the policy and process contained in the MCO Policy and Procedure Guide for referral of cases and coordination with the Department Division of Program Integrity for fraud and abuse complaints regarding Medicaid MCO Members and Providers.

13.24 Fraud and Abuse Compliance Plan

The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse. The arrangements or procedures must include the following:

- 1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.
- 2) The designation of a compliance officer and a compliance committee that are accountable to senior management.
- 3) Effective training and education for the compliance officer and the organization's employees.
- 4) Effective lines of communication between the compliance officer and the organization's employees.
- 5) Enforcement of standards through well-publicized disciplinary guidelines.
- 6) Provision for internal monitoring and auditing.
- 7) Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to its contract.

13.25 Integration

This Contract shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

13.26 Hold Harmless

The Contractor shall indemnify, defend, protect, and hold harmless Department and any of its officers, agents, and employees from:

- 13.26.1 Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the Contractor in connection with the performance of this Contract;
- 13.26.2 Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or Federal Medicaid regulations or legal statutes, by Contractor, its agents, officers, employees, or subcontractors in the performance of this Contract;
- 13.26.3 Any claims for damages or losses resulting to any person or firm injured or damaged by Contractor, its agents, officers, employees, or subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Contract in a manner not authorized by the Contract or by Federal or State regulations or statutes;
- 13.26.4 Any failure of the Contractor, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;
- 13.26.5 Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of Department in connection with the defense of claims for such injuries, losses, claims, or damages specified above;
- 13.26.6 Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against Department or their agents, officers or employees, through the intentional conduct, negligence or omission of the Contractor, its agents, officers, employees or subcontractors.

In the event that, due to circumstances not reasonably within the control of Contractor or Department, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the Contractor, Department, or subcontractor(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services; provided, however, that so long as the Contractor's certificate of authority remains in full force and effect, the Contractor shall be liable for the covered services required to be provided or arranged for in accordance with this Contract.

13.27 Hold Harmless as to the Medicaid MCO Program Members

In accordance with the requirements of S.C Code Ann. § 38-33-130(b) (Supp. 2001, as amended), and as a condition of participation as a health care provider, the Contractor hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Medicaid MCO Members of Contractor, or persons acting on their behalf, for health care services which are rendered to such members by the Contractor and its subcontractors, and which are covered

benefits under the members evidence of coverage. This provision applies to all covered health care services furnished to the Medicaid MCO Member for which the State does not pay the Contractor or the State or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referred, or other arrangement during the time the member is enrolled in, or otherwise entitled to benefits promised by the Contractor. The Contractor further agrees that the Medicaid MCO Member shall not be held liable for payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the MCO provided the service directly. The Contractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by Contractor and insolvency of Contractor. The Contractor further agrees that this provision shall be construed to be for the benefit of Medicaid MCO Program members of Contractor, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Contractor and such members, or persons acting on their behalf.

13.28 Non-Discrimination

The Contractor agrees that no person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of the Contractor's MCO program or be otherwise subjected to discrimination in the performance of this Contract or in the employment practices of the Contractor. The Contractor shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination. This provision shall be included in all subcontracts.

13.29 Confidentiality of Information

The Contractor shall assure that all material and information, in particular information relating to members or potential members, which is provided to or obtained by or through the Contractor's performance under this Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under state and federal laws. The Contractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Contract.

All information as to personal facts and circumstances concerning members or potential members obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of the Department or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Contract.

13.30 Rate Adjustment

The Contractor and Department both agree that the capitation rates identified in Appendix B of this Contract, shall remain in effect during the period identified on the HMO Capitation Rates Schedule. Rates may be adjusted during the contract period based on Department and actuarial analysis, and subject to CMS review and approval.

The Contractor and Department both agree the adjustments to the capitation rate(s) required pursuant to this section shall occur only by written amendment to this Contract. The Contractor will have seven (7) calendar days to execute the rate amendment. Should the Contractor fail to do so the Department may at its discretion impose fine equal to \$1500 per day and may also terminate the contract.

13.31 Employment of Personnel

In all hiring or employment made possible by or resulting from this Contract, the Contractor agrees that (1) there shall be no discrimination against any employee or applicant for employment because of handicap, age, race, color, religion, sex, or national origin, and that (2) affirmative action shall be taken to ensure that applicants are employed and that employees are treated during employment without regard to their handicap, age, race, color, religion, sex, or national origin. This requirement shall apply to, but not be limited to, the following: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff, termination, rates of pay or other forms of compensation, and selection for training including apprenticeship. The Contractor further agrees to give public notice in conspicuous places available to employees and applicants for employment setting forth the provisions of this section. All solicitations or advertisements for employees shall state that all qualified applicants will receive consideration for employment without regard to handicap, age, race, color, religion, sex, or national origin. All inquiries made to the Contractor concerning employment shall be answered without regard to handicap, age, race, color, religion, sex, or national origin. All responses to inquiries made to the Contractor concerning employment made possible as a result of this Contract shall conform to federal, state, and local regulations.

13.32 Political Activity

None of the funds, materials, property, or services provided directly or indirectly under this Contract shall be used for any partisan political activity, or to further the election or defeat of any candidate for public office, or otherwise in violation of the provisions of the "Hatch Act".

13.33 Force Majeure

The Contractor shall not be liable for any excess costs if the failure to perform the Contract arises out of causes beyond the control and without the fault or negligence of the Contractor. Such causes may include, but are not restricted to, acts of God or of the public enemy; acts of the Government in either its sovereign or contractual capacity; fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and

unusually severe weather; but in every case the failure to perform must be beyond the control and without the fault or negligence of the Contractor. If the failure to perform is caused by default of a subcontractor, and if such default arises out of causes beyond the control of both the Contractor and subcontractor, and without the fault or negligence of either of them, the Contractor shall not be liable for any excess costs for failure to perform, unless the supplies or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required delivery schedule.

Department shall not be liable for any excess cost to the Contractor for Department's failure to perform the duties required by this Contract if such failure arises out of causes beyond the control and without the result of fault or negligence on the part of Department. In all cases, the failure to perform must be beyond the control and without the fault or negligence of Department.

13.34 Conflict of Interest

The Contractor represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Contractor further covenants that, in the performance of the Contract, no person having any such known interests shall be employed.

13.35 Safety Precautions

Department and HHS assume no responsibility with respect to accidents, illnesses, or claims arising out of any activity performed under this Contract. The Contractor shall take necessary steps to ensure or protect its clients, itself, and its personnel. The Contractor agrees to comply with all applicable local, state, and federal occupational and safety acts, rules, and regulations.

13.36 Contractor's Appeal Rights

If any dispute shall arise under the terms of this Contract, the sole and exclusive remedy shall be the filing of a Notice of Appeal within thirty (30) calendar days of receipt of written notice of Department's action or decision which forms the basis of the appeal. Administrative appeals shall be in accordance with 27 S.C. Code Ann. Regs. §126-150, et seq. (1976, as amended), and the Administrative Procedures Act, S.C. Code Ann. § 1-23-310, et seq. (1976, as amended). Judicial review of any final Department administrative decisions shall be in accordance with S.C. Code Ann. § 1-23-380 (1976, as amended).

13.37 Loss of Federal Financial Participation (FFP)

The Contractor hereby agrees to be liable for any loss of FFP suffered by Department due to the Contractor's, or its subcontractors', failure to perform the services as required under this Contract. Payments provided for under this Contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS in accordance with the requirements in 42 CFR §438.730.

13.38 Sharing of Information

The Contractor understands and agrees that Department and SCDOI may share any and all documents and information, including confidential documents and information, related to compliance with this Contract and any and all South Carolina insurance laws applicable to Health Maintenance Organizations. The Contractor further understands and agrees that the sharing of information between Department and SCDOI is necessary for the proper administration of the Medicaid MCO Program.

13.39 HIPAA Compliance

The Contractor shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the rules and regulations promulgated thereunder (45 CFR Parts 160, 162, and 164). The Contractor shall ensure compliance with all HIPAA requirements across all systems and services related to this contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations.

13.40 Prohibited Payments

Payment for the following shall not be made:

- 13.41.1 Organ transplants, unless the State plan has written standards meeting coverage guidelines specified; Non-emergency services provided by or under the direction of an excluded individual;
- 13.40.2 Any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997;
- 13.40.3 Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan; and
- 13.40.4 Any amount expended for home health care services unless the organization provides the appropriate surety bond.

13.41 Employee Education about False Claims Recovery

If the Contractor receives annual Medicaid payments of at least \$5,000,000, the Contractor must comply with Section 6032 of the Deficit Reduction Act (DRA) of 2005.

13.42 HIPAA Business Associate

Individually identifiable health information is to be protected in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as agreed upon in Appendix C.

13.43 Software Reporting Requirement

All reports submitted to Department by the Contractor must be in a format accessible and modifiable by the standard Microsoft Office Suite of products or in a format accepted and approved by Department.

13.44 National Provider Identifier

The HIPAA Standard Unique Health Identifier regulations (45 CFR Part 162 Subparts A & D) require that all covered entities (health plans, health care clearinghouses, and those health care providers who transmit any health information in electronic form in connection with a standard transaction) must use the identifier obtained from the National Plan and Provider Enumeration System (NPPES).

Pursuant to the HIPAA Standard Unique Health Identifier regulations (45 CFR Part 162 Subparts A & D), and if the provider is a covered health care provider as defined in 45 CFR §162.402, the provider agrees to disclose its National Provider Identifier (NPI) to DEPARTMENT once obtained from the NPPES. The provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with Department.

13.45 Debarment/Suspension/Exclusion

The Contractor agrees to comply with all applicable provisions of 2 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. As a condition of enrollment, the Contractor should screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program, and/or all federal health care programs. To make this determination, the Contractor may search the LEIE website located at <http://www.oig.hhs.gov/fraud/exclusions.asp>.

The Contractor will conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search, and any exclusion information discovered should be immediately reported to Department. The Contractor shall provide a monthly electronic record of all searches it is required to conduct monthly. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from Medicaid for that prescription. Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid beneficiaries. See Section 1128A(a)(6) of the Social Security Act and 42 CFR 1003.102(a)(2).

13.46 Payment of Providers

Payment of both contracted and non-participating providers shall, at a minimum, follow the same standards as those contained in 42 CFR §447.45 (d)(1)-(3), (5) and (6) as determined by Department. This includes the following: Providers must submit all claims no later than 12 months from the date of service. The Contractor shall pay 90% of all clean claims from Providers, either in individual or group practice or who

practice in shared health facilities, within thirty (30) days of the date of receipt. The Contractor shall pay 99% of all clean claims from Providers either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt. These provisions shall also apply to payments to hospitals. The date of receipt is the date the Contractor 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. The MCO and its providers may, by mutual agreement and in writing, establish an alternative payment schedule.



IN WITNESS WHEREOF, the Department and the Contractor, by their authorized agents, have executed this Contract as of the first day of July 2012.

SOUTH CAROLINA DEPARTMENT OF
HEALTH AND HUMAN SERVICES
"DEPARTMENT"

«providercaps»
"CONTRACTOR"

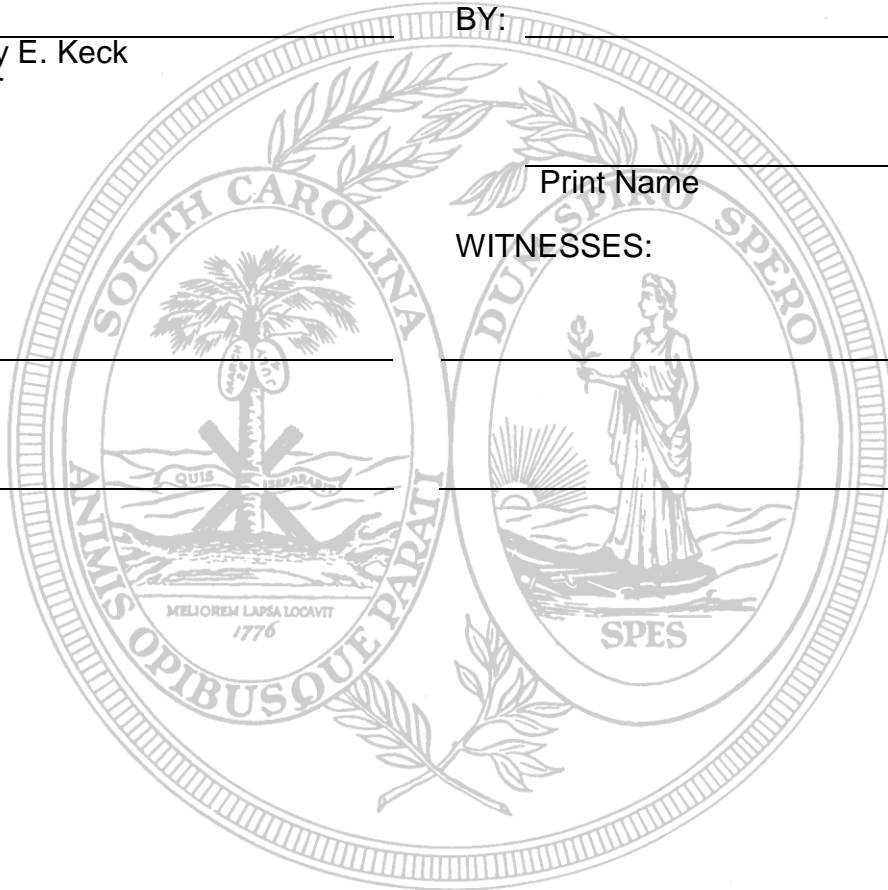
BY: _____
Anthony E. Keck
Director

BY: _____

WITNESSES:

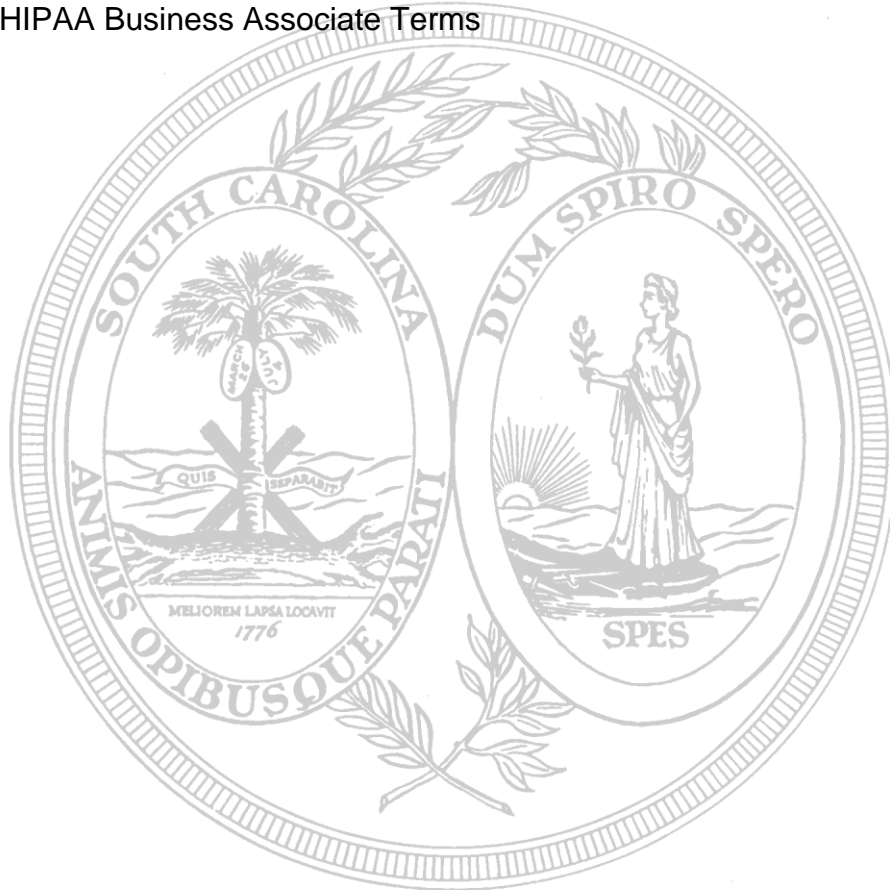
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WITNESSES:



LIST OF APPENDICES

- A. Definitions
- B. Capitation Rates and Reimbursement Methodology
- C. HIPAA Business Associate Terms



Appendix A

Definitions

DEFINITION OF TERMS AND ACRONYMS

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

AAFP – Academy of Family Physicians.

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

ACIP – Centers for Disease Control Advisory Committee on Immunization Practices.

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

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

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

Actuarially sound capitation rates - Capitation rates that--(1) have been developed in accordance with generally accepted actuarial principles and practices; (2) are appropriate for the populations to be covered, and the services to be furnished under the contract; and (3) have been certified, as meeting the requirements of this paragraph, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

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

Adjustments to smooth data – Adjustments made, by cost-neutral methods, across rate cells, to compensate for distortions in costs, utilization, or the number of eligibles.

AFDC/Family Independence - Aid to Families with Dependent Children.

Appeal- means a request for review of an action.

Applicant - An individual seeking Medicaid eligibility through written application.

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

CFR - Code of Federal Regulations.

CPT - Current Procedural Terminology, fourth edition, revised 2007.

Capitation Payment - The monthly payment which is paid by Department to a Contractor for each enrolled Medicaid MCO Program member for the provision of benefits during the payment period.

Care Coordination - The manner or practice of planning, directing and coordinating health care needs and services of Medicaid MCO Program members.

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

Case - An event or situation

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

Certificate of Coverage - The term describing services and supplies provided to Medicaid MCO Program members, which includes specific information on benefits, coverage limitations and services not covered. The term "certificate of coverage" is interchangeable with the term "evidence of coverage".

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 - Universal claim form, required by CMS, to be used by non-institutional and institutional Contractors that do not use the UB-92.

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

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

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

Contract Dispute - A circumstance whereby the Contractor and DEPARTMENT are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under this Contract.

Conversion Coverage - Individual coverage available to a member who is no longer covered under the Medicaid MCO Contract coverage.

Core Benefits - A schedule of health care benefits provided to Medicaid MCO Program members enrolled in the Contractor's plan as specified under the terms of this Contract.

Cost Neutral – The mechanism used to smooth data, share risk, or adjust for risk that will recognize both higher and lower expected costs and is not intended to create a net aggregate gain or loss across all payments.

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

Contractor - The domestic licensed MCO that has executed a formal agreement with DEPARTMENT to enroll and serve Medicaid MCO Program members under the terms of this contract. The term Contractor shall include all employees, subcontractors, agents, volunteers, and anyone acting on behalf of, in the interest of, or for a Contractor.

DAODAS - Department of Alcohol and Other Drug Abuse Services.

DDSN - Department of Disabilities and Special Needs.

DHEC - Department of Health and Environmental Control.

Days - Calendar days unless otherwise specified.

Department- South Carolina Department of Health and Human Services (SCDHHS)

Disenrollment - Action taken by DEPARTMENT or its designee to remove a Medicaid MCO Program member from the Contractor's plan following the receipt and approval of a written request for disenrollment or a determination made by Department or its designee that the member is no longer eligible for Medicaid or the Medicaid MCO Program.

Direct Marketing/Cold call - Any unsolicited personal contact with or solicitation of Medicaid applicants/eligibles in person, through direct mail advertising or telemarketing by an employee or agent of the MCO for the purpose of influencing an individual to enroll with the MCO plan.

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

Dual-eligibles - Applicants that receive Medicaid and Medicare benefits.

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

EPSDT - An Early and Periodic Screening, Diagnosis and Treatment Program mandated by Title XIX of the Social Security Act.

Eligible(s) - A person who has been determined eligible to receive services as provided for in the SC State Plan for Medical Assistance under Title XIX.

Emergency Medical Condition - 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 Program member regardless of how the service was reimbursed and regardless of provider type, practice specialty, or place of services. This would include expanded services/benefits as defined in this Contract.

Enrollment - The process in which a Medicaid eligible selects or is assigned to an MCO and goes through a managed care educational process as provided by DEPARTMENT or its agent.

Enrollment (Voluntary) - The process in which an applicant/recipient selects an Contractor and goes through an educational process to become a Medicaid MCO Program member of the Contractor.

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

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

Evidence of Coverage - The term which describes services and supplies provided to Medicaid MCO Program members, which includes specific information on benefits, coverage limitations and services not covered. The term "evidence of coverage" is interchangeable with the term "certificate of coverage".

FPL - Federal Poverty Level.

FFP - Federal Financial Participation - Any funds, either title or grant, from the Federal Government.

FTE - A full time equivalent position.

FQHC - A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants. A FQHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A FQHC provides a wide range of primary care and enhanced services in a Medically underserved Area.

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

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

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

GAO - General Accounting Office.

Grievance- means an expression of dissatisfaction about any matter other than an action. The term is also used to refer to the overall system that includes grievances and appeals handled at the MCO level. (Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights.)

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

certified respiratory therapy technician; with appropriate licensure or certification with the state of South Carolina.

HCPCS - CMS's Common Procedure Coding System.

Health Maintenance Organization (HMO) (Contractor) - 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.

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

HHS - United States Department of Health and Human Services.

Home and Community Based Services - In-home or community-based support services that assist persons with long term care needs to remain at home.

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

ICD-CM - International Classification of Disease, Clinical Modification..

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

Inmate - On who is housed in or confined to a correctional facility (e.g. prison, prison facility, jail etc) This does not include individuals on Probation or Parole or who are participating in a community program.

Inquiry – A routine question/s about a benefit. An inquiry does not automatically invoke a plan sponsor's grievance or coverage determination process.

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

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

MMIS – Medicaid Management Information System.

Managed Care Organization – An entity that has, or is seeking to qualify for, a comprehensive risk contract that is—(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 term "Managed Care Plan" is interchangeable with the terms "Contractor", "Plan", or "HMO/MCO".

Marketing – Any communication approved by DEPARTMENT, from an MCO to a Medicaid recipient who is not enrolled in that entity, that can be reasonably interpreted as intended to influence the recipient to enroll in that particular MCO Medicaid product, or either to not enroll, or to disenroll from, another MCO Medicaid product.

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

Mass Media - A method of public advertising that can create plan name recognition among a large number of Medicaid recipients and can assist in educating them about potential health care choices. Examples of mass media are radio spots, television advertisements, newspaper advertisements, newsletters, and video in doctor's office waiting rooms.

Medicaid - The medical assistance program authorized by Title XIX of the Social Security Act.

Medicaid Provider - An institution, facility, agency, person, corporation, partnership, or association approved by DEPARTMENT which accepts payment in full for providing benefits, to Medicaid recipients and is paid amounts pursuant to approved Medicaid reimbursement provisions, regulations and schedules.

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

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

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 Program member; (b) are provided at an appropriate

facility and at the appropriate level of care for the treatment of the Medicaid MCO Program member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

Member or Medicaid MCO Member - An eligible person(s) who voluntarily enrolls with a DEPARTMENT approved Medicaid MCO Contractor.

NCQA - The National Committee for Quality Assurance is a private, 501(c)(3) non-for-profit organization founded in 1990, and dedicated to improving health care quality. .

NDC - National Drug Code.

National Practitioner Data Bank - A central repository for adverse action and medical malpractice payments. (1-800-767-6732)

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

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

Non-Covered Services - Services not covered under the SC State Plan for Medical Assistance.

Non-Emergency - An encounter with a health care provider by a Medicaid MCO Program member who has presentation of medical signs and symptoms, that do not require immediate medical attention.

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

Non-Risk Contract – A contract under which the contractor—(1) is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42CFR § 447.362; and (2) May be reimbursed by the State at the end of the Contract period on the basis of the incurred costs, subject to the specified limits.

Out-of-Plan Services - Medicaid services not included in the Contractor's Core Benefits and reimbursed fee-for-service by the State.

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).

Plan - The term " Plan" is interchangeable with the terms "Contractor ," "Managed Care Plan" or "HMO/MCO".

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

Post-stabilization services - Covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition, or improve or resolve the member's condition.

Preventative and Rehabilitative Services for Primary Care Enhancement - A package of services designed to help maximize the treatment benefits/outcomes for those patients who have serious medical conditions and/or who exhibit lifestyle, psycho-social, and/or environmental risk factors.

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

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

Prior Authorization - The act of authorizing specific approved services by the Contractor before they are rendered.

Program - The method of provision of Title XIX services to South Carolina recipients as provided for in the SC State Plan for Medical Assistance and Department regulations.

Provider - any individual, group, physicians (such as but not limited includes Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Outpatient Center (free standing or owned) Clinics and Laboratories) furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the Managed Care Program, any individual, group, physicians (including but not limited to Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary providers, Clinics, Outpatient Centers (free standing or owned) and Laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.

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 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

Recipient - A person who is determined eligible to receive services as provided for in the SC State Plan for Medical Assistance.

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

Relationship – Relationship is described as follows for the purposes of any business affiliations discussed in § 5 of this Contract:

- ◆ A director, officer, or partner of the MCO;
- ◆ A person with beneficial ownership of five (5%) percent or more of the MCO's equity; or
- ◆ A person with an employment, consulting or other arrangement (e.g., providers) with the MCO under its contract with the State.

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

RHC - A South Carolina licensed rural health clinic is certified by the CMS and receiving Public Health Services grants. A RHC eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. A RHC provides a wide range of primary care and enhanced services in a medically underserved area.

Risk - A chance of loss assumed by the Contractor which arises if the cost of providing core benefits and covered services to Medicaid MCO Program members exceeds the capitation payment made by DEPARTMENT to the Contractor under the terms of this Contract.

Risk Corridor –A risk sharing mechanism in which States and Contractors share in both profits and losses under the Contract outside predetermined threshold amounts, so that after an initial Corridor in which the Contractor is responsible for all losses or retains all profits, the State contributes a portion toward any additional losses, and receives a portion of any additional profits.

Routine Care – Treatment of a condition which would have no adverse effects if not treated within 24 hours or could be treated in a less acute setting (e.g., physician's office) or by the patient.

Service Area - The geographic area in which the Contractor is authorized to accept enrollment of eligible Medicaid MCO Program members into the Contractor's plan. The service area must be approved by SCDOI.

SCDOI - South Carolina Department of Insurance.

SSA - Social Security Administration.

SSI - Supplemental Security Income.

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

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

Social Services - Medical assistance, rehabilitation, and other services defined by Title XIX, and DEPARTMENT regulations.

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

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

Subcontractor - Any organization or person who provides any functions or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to Department under the terms of this Contract.

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.

Termination - The member's loss of eligibility for the S.C. Medicaid MCO Program and therefore automatic disenrollment from the Contractor's plan.

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

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

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

UB-04 - A uniform bill for inpatient and outpatient hospital billing. The required form is the UB-04 CMS 1500.

Universal Rate - The Universal rate is the rate paid to new health plans that lack membership to be risk-adjusted. It is a risk-adjusted PMPM with the fee-for-service (FFS) data being the base data for calculating the PMPM. The risk-adjustment is the relative risk score between the Universe (HMO + FFS population) and FFS population.

Urgent Care - Medical conditions that require attention within forty eight (48) hours. If the condition is left untreated for 48 hours or more, it could develop into an emergency condition.

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

Well Care - A routine medical visit for one of the following: EPSDT visit, family planning, follow-up to a previously treated condition or illness, adult and/or any other visit for other than the treatment of an illness.

Appendix B
Capitation Rates and Reimbursement Methodology

South Carolina
Department of Health and Human Services
MCO Capitation Rates

Effective July 1, 2012 – December 31, 2013
(«provider»)

Appendix C
HIPAA Business Associate Terms

HIPAA BUSINESS ASSOCIATE

A. Purpose:

The South Carolina Department of Health and Human Services (Covered Entity) and CONTRACTOR (Business Associate) agree to the terms of this Appendix for the purpose of protecting the privacy of individually identifiable health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in performing the functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract between the parties.

B. Definitions (Terms used in this Section, but not otherwise defined, shall have the same meaning as set forth for those terms in HIPAA. A change to HIPAA which modifies any defined HIPAA term, or which alters the regulatory citation for the definition shall be deemed incorporated into this Appendix).

1. Business Associate. "Business Associate" shall mean the CONTRACTOR. Where the term "business associate" appears without an initial capital letter, it shall have the same meaning as the term "business associate" in 45 CFR § 160.103.
2. Covered Entity. "Covered Entity" shall mean SCDHHS.
3. Data Aggregation. "Data Aggregation" shall have the meaning given to the term in 45 CFR § 164.501.
4. Designated Record Set. "Designated Record Set" shall have the meaning given the term in 45 CFR § 164.501.
5. Electronic Protected Health Information and/or EPHI. "Electronic Protected Health Information" or "EPHI" shall have the meaning given the term in 45 CFR § 160.103, and shall include, without limitation, any EPHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity.
6. HIPAA. "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, as amended, and related HIPAA regulations (45 CFR Parts 160-164).
7. HITECH. "HITECH" means the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.
8. Individual. "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

9. Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information, and Security Standards for the Protection of Electronic Protected Health Information (the "Security Rule") that are codified at 45 CFR Parts 160 and Part 164, Subparts A, C, and E and any other applicable provision of HIPAA, and any amendments thereto, including HITECH.
10. Protected Health Information or PHI. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, and shall include, without limitation, any PHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity. Unless otherwise stated in this Agreement, any provision, restriction, or obligation in this Appendix related to the use of PHI shall apply equally to EPHI.
11. Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103, and any additional requirements created under HITECH.
12. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
13. Security Incident. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system as provided in 45 C.F.R. § 164.304.
14. Unsecured PHI. "Unsecured PHI" shall have the same definition that the Secretary gives the term in guidance issued pursuant to § 13402 of HITECH.

C. Business Associate Agrees to:

1. Not use or disclose PHI or EPHI other than as permitted or required by the Contract or as Required By Law.
2. Develop, implement, maintain, and use appropriate safeguards to prevent any use or disclosure of the PHI or EPHI other than as provided by this Appendix, and to implement administrative, physical, and technical safeguards as required by sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations and HITECH in order to protect the confidentiality, integrity, and availability of EPHI or PHI that Business Associate creates, receives, maintains, or transmits, to the same extent as if Business Associate were a Covered Entity. See HITECH § 13401.

3. The additional requirements of Title XIII of HITECH that relate to privacy and security and that are made applicable with respect to covered entities shall also be applicable to Business Associate and shall be and by this reference hereby incorporated into this Appendix.
4. Adopt the technology and methodology standards provided in any guidance issued by the Secretary pursuant to HITECH § 13401-13402.
5. Mitigate to the extent practicable, any harmful effect known to Business Associate if Business Associate uses/discloses PHI in violation of the Contract or this Appendix and to notify Covered Entity of any breach of unsecured PHI, as required under HITECH § 13402.
6. Immediately report to Covered Entity any breaches in privacy or security that compromise PHI or EPHI. Security and/or privacy breaches should be reported to:

South Carolina Department of Health and Human Services
Office of General Counsel
Post Office Box 8206
Columbia, South Carolina 29202-8206
Phone: (803) 898-2795
Fax: (803) 255-8210

The Report shall include the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during the breach. If the breach involves the Unsecured PHI of more than 500 residents of South Carolina or residents of a certain region, or is reasonably believed to have been accessed, acquired or disclosed during such incident, the Covered Entity will also notify the prominent media outlets. The media outlets must serve the geographic area affected.

SCDHHS may impose a fine of \$300 per day from the date that the Business Associate knew or should have known of any breach in privacy or security that compromises PHI to the date that SCDHHS becomes aware of the breach.

SCDHHS may impose a fine of up to \$25,000 for any negligent breach in privacy or security that compromises PHI.

7. Ensure that any agent/subcontractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Appendix. Business Associate must obtain, prior to making any permitted disclosure to any agent/subcontractor, reasonable assurances from such third party that such PHI will be held secure and confidential as provided pursuant to this Appendix and only disclosed as required by law or for the purposes for which it was disclosed to such third party, and that any breaches of confidentiality of the PHI which become known to such third party will be immediately reported to Business Associate. As part of obtaining this reasonable assurance, Business Associate agrees to enter

into a Business Associate Agreement with each of its subcontractors pursuant to 45 CFR § 164.308(b)(1) and HITECH § 13401.

8. If the Business Associate has PHI in a Designated Record, provide access at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.
9. If the Business Associate has PHI in a Designated Record Set, make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.
10. Make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.
11. Document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
12. Provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with Section C.8 of this Appendix, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.
13. Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as iPods, and MP3 and MP4 players), and personal organizers. Portable devices that perform computing, data manipulation or data transmission are called intelligent portable devices.
14. Business Associate understands and agrees that, should SCDHHS be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this Section, Business Associate shall be liable to SCDHHS for any damages, penalties and/or fines assessed against

SCDHHS as a result of Business Associate's material breach. SCDHHS is authorized to recoup any and all such damages, penalties and/or fines assessed against SCDHHS by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which SCDHHS may be obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and SCDHHS, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

D. Permitted Uses and Disclosures by Business Associate

1. Except as limited in this Appendix, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract noted in A. provided that such use would not violate the Privacy Rule if done by Covered Entity or the Covered Entity's minimum necessary policies and procedures. Unless otherwise permitted in this Appendix, in the Contract noted in A. above or as Required by Law, Business Associate may not disclose or re-disclose PHI except to Covered Entity.
2. Except as limited in this Appendix, Business Associate may use or disclose PHI for the proper internal management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide services to Covered Entity under the above noted Contract.
3. Except as limited in this Appendix, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).
4. Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with § 164.502(j)(1).

E. Covered Entity Shall:

1. Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
2. Notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

3. Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.
4. Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

F. Term and Termination

1. The terms of this Appendix shall be effective immediately upon award of the Contract noted in A. and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.
2. Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall:
 - a. Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; OR
 - b. Immediately terminate the Contract if Business Associate has breached a material term of this Appendix and cure is not possible; OR
 - c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.
3. Effect of Termination.
 - a. Except as provided in paragraph (2) below, upon termination of the Contract, for any reason, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision applies to PHI in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.
 - b. In the event that Business Associate determines that returning the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, Business Associate shall extend the protections of this Appendix to such PHI and limit further uses and disclosures of such

PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

G. Security Compliance

This Section shall be effective on the applicable enforcement date of the Security Standards. Business Associate agrees to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Covered Entity, and will require that its agents and subcontractors to whom it provides such information do the same. Further, Business Associate agrees to comply with Covered Entity's security policies and procedures. Business Associate also agrees to provide Covered Entity with access to and information concerning Business Associate's security and confidentiality policies, processes, and practices that affect Electronic PHI provided to or created by Business Associate pursuant to the Agreement upon reasonable request of the Covered Entity. Covered Entity shall determine if Business Associate's security and confidentiality practices, policies, and processes comply with HIPAA, as amended from time to time, and all regulations promulgated under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

H. Miscellaneous

1. A reference in this Appendix to a section in the Privacy Rule means the section as in effect or as amended.
2. The Parties agree to amend this Appendix as necessary to comply with HIPAA and other applicable law.
3. Any provision related to the use, disclosure, access, or protection of EPHI or PHI or that by its terms should survive termination of this Agreement shall survive termination.
4. Any ambiguity in this Appendix shall be resolved to permit Covered Entity to comply with the Privacy Rule.