AMENDMENT NUMBER THREE

TO THE CONTRACT

BETWEEN

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

Standard Contract Managed Care Organization

FOR THE PURCHASE AND PROVISION OF MEDICAL SERVICES UNDER THE SOUTH CAROLINA MEDICAID MCO PROGRAM

THIS AMENDMENT is entered into as of the first day of October 2009 by and between South Carolina Department of Health and Human Services, Post Office Box 8206, 1801 Main Street, Columbia, South Carolina, 29202-8206, (hereinafter referred to as "SCDHHS") and **Standard Contract Managed Care Organization** (hereinafter referred to as "Contractor").

WHEREAS, Section 1.7, Amendments, allows for an amendment to the April 1, 2008 Contract, as amended, when mutually agreed upon by the parties;

WHEREAS, SCDHHS has used its best efforts to denote changes that have been made to the Contract pursuant to this Amendment;

WHEREAS, the Contractor understands and agrees that it shall be the responsibility of the Contractor to familiarize itself and comply with all of the requirements outlined in this Amendment, as well as comply with the contract provisions which have not changed as a result of this Amendment;

NOW, THEREFORE, the following revisions shall be accomplished and incorporated in the April 1, 2008 Contract, as amended, as if fully set forth therein.

REVISION I

NOW, THEREFORE, RECITALS, as shown in the April 1, 2008 contract, as amended, shall be revised and amended and shall now read as follows:

> "WHEREAS, the South Carolina Department of Health and Human Services is the single state agency responsible for the administration of the Medical Assistance Plan under Title XIX of the Social Security Act; 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 SCDHHS 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 (200~~5~~**8**, 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 MCO 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 Managed Care Organization; 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 Program 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:"

REVISION II

NOW, THEREFORE, 1 GENERAL PROVISIONS, as shown in the April 1, 2008 contract, as amended, shall be revised and amended and shall now read as follows:

"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 SCDHHS, and shall continue in full force and effect from April 1, 2008 until March 31, 2010 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 SCDHHS, 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 or three (3) calendar days have elapsed after posting if 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 SCDHHS:

South Carolina Department of Health and Human Services
Office of the Director
1801 Main Street
Post Office Box 8206
Columbia, South Carolina 29202-820**6**

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. 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.

1.3 Definitions

The terms used in this Contract shall be construed and/or interpreted in accordance with the definitions set forth in Appendix A - Definitions, unless the context in which a term(s) is used expressly provides otherwise.

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 SCDHHS policies and procedures in effect throughout the duration of this Contract period. The Contractor shall comply with all SCDHHS 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.

SCDHHS, at its discretion, will issue Medicaid bulletins to inform the Contractor of changes in policies and procedures which may affect this Contract. The SCDHHS 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 nonrisk 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 SCDHHS and the Contractor in which payment hereunder shall exceed One Hundred Thousand Dollars ($100,000.00). If CMS does not approve this Contract entered into under the Terms & Conditions described herein, 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 anytime 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 SCDHHS, CMS, and **the** CMS Regional Office prior to its implementation."

REVISION III

NOW, THEREFORE, 2 FINANCIAL MANAGEMENT, 2.1, Capitation Payments, as shown in the April 1, 2008 contract, as amended, shall be revised and amended and shall now read as follows:

"2 FINANCIAL MANAGEMENT

2.1 Capitation Payments

The Contractor agrees to accept the capitation payments remitted by SCDHHS to the Contractor as payment in full for all services provided to Medicaid MCO Program members pursuant to this Contract. The capitation payment is equal to the monthly number of members in each SCDHHS member category multiplied by the capitation rate established for each group per month plus a maternity kicker payment for each member who delivers during the month ~~and a newborn kicker payment for each infant born during the month who meets the criteria explained in the MCO Policy and Procedure Guide. The newborn kicker payment is the only payment the MCO will receive for the birth month.~~

2.1.1 SCDHHS reserves the right to defer remittance of the capitation payment for July until the first MMIS payment cycle in July to comply with state 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 were 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 ~~if the services were furnished by a provider which is not a FQHC or RHC~~**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 provider 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 provider at a level and amount that exceeds the Medicaid fee-for-service reimbursement amount.** ~~Contractor *may elect* to make payment to the FQHC/RHC provider at a level and amount that exceeds the minimum requirements described in **§ 2.2.2**, above, and such payment *may* equal the level and amount of payment that the FQHC/RHC provider would have been entitled to receive as reimbursement from the South Carolina Medicaid Program if the service had been furnished to a Medicaid recipient who was not enrolled with a managed care provider at the time the service was rendered.~~

~~2.2.4 To the extent that payments by Contractor to any FQHC or RHC are at a level and amount that require DHHS to make supplemental payments under the terms of §1902(a)(13)(C) of the Social Security Act [as amended by the Balanced Budget Act of 1997], DHHS shall be responsible for making such payments to the FQHCs or RHCs.~~

2.2.~~5~~**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 SCDHHS for ~~reasonable cost based~~ **State Plan required** reconciliation purposes. This information shall be submitted in the format required by SCDHHS **as contained in the MCO Policy and Procedure Guide**.

2.3 Co-payments

Co-Payments for Adult Medicaid MCO Program members aged 19 and older will be allowed under this contract. Any cost sharing imposed on Medicaid Program members must be in accordance with 42 CFR §§447.50 through 447.58.

2.4 Ancillary Services Provided at the Hospital

Ancillary services which are provided in the hospital include, but are not limited to, radiology, pathology, emergency medicine and anesthesiology. When the Contractor's ~~network providers/subcontractors authorize~~**member is provided** these services (either inpatient or outpatient) 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. ~~This is also required for emergency services rendered by non-network providers for ancillary services provided in a hospital setting~~**Prior authorization for these 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 SCDHHS are due immediately upon notification to the Contractor by SCDHHS unless otherwise authorized in writing by SCDHHS. SCDHHS, at its discretion, reserves the right to collect amounts due by withholding future capitated payments. SCDHHS 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 HHS in the Federal Register.

In addition, the Contractor shall reimburse SCDHHS for any federal disallowances or sanctions imposed on SCDHHS 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 SCDHHS by the United States Department of Health and Human Services (HHS) as a result of the disallowance. Payments of funds being returned to SCDHHS 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

Medicaid payment is secondary to other sources of payment for covered health care. Under state law, the SCDHHS has an assignment of rights to any other insurance coverage for a Medicaid recipient and subrogation rights, both only to the extent that Medicaid has paid for a service. The Medicaid effort responsible for enforcing assignment and subrogation rights is called "Third Party Liability" or "TPL." Under this Contract, the SCDHHS assigns its rights to such payments to the Contractor for any services covered by the Contractor which were received by a member during a month for which the Medicaid program paid the monthly payment to the Contractor. The Contractor shall report all third party recoveries for its Medicaid members to the SCDHHS in the format specified in 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 SCDHHS in the same format as **specified in the** MCO Policy and Procedure Guide. The Contractor is encouraged to pursue assignment and subrogation; See MCO Policy and Procedure Guide, Third Party Liability. As a condition of eligibility, recipients must cooperate with the SCDHHS in pursuit of other liable parties and Medicaid MCO Program members must cooperate with the Contractor in pursuit of other liable parties wherever such cooperation is reasonable.

2.6.1 SCDHHS will share data with the Contractor regarding any insurance coverage it discovers for any covered Medicaid MCO Program member. While SCDHHS will make reasonable efforts to ensure that the shared data is accurate, SCDHHS cannot guarantee the accuracy of the data. (See MCO Policy and Procedure Guide)

2.6.2 When the Contractor has determined that other insurance coverage exists for which the SCDHHS has not shared data with the Contractor already, the Contractor shall notify SCDHHS of this coverage.(See the MCO Policy and Procedure Guide**,** Third Party Liability**)**

2.6.3 If a Medicaid MCO Program member refuses to cooperate with the Contractor in pursuit of other liable parties, the Contractor will request the assistance of SCDHHS.

2.7 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 SCDHHS from any loses sustained through any fraudulent or dishonest act or acts committed by any employees of the Contractor and subcontractors.

2.8 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.

2.9 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 member enrollment.

2.10 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 25**A** S.C. Code **Ann.** Reg. §69-22 (**Supp**. 2000, as amended), as amended and approved by SCDOI"

2.11 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, SCDHHS shall prohibit the Contractor from engaging in enrollment activities, shall cease to process new enrollments and shall not renew the Contractor's Contract until the required balance is achieved, and certified by the SCDOI.

2.12 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 SCDHHS 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.

2.13 Proof of Insurance

At any time, upon the request of SCDHHS 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.

2.14 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).

2.15 Errors and Omissions Insurance

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

REVISION IV

NOW, THEREFORE, 3 CONTRACTOR'S PLAN ADMINISTRATION AND MANAGEMENT, as shown in the April 1, 2008 contract, as amended, shall be revised and amended and shall now read as follows:

“3 CONTRACTOR'S 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 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. ~~the Medical Director will chair the CQI committee.~~

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 ~~Contractor must have a~~**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

A Medicaid MCO Program Contractor shall be: (1) a South Carolina domestic licensed MCO which meets the Advanced Directive requirements as stated in 42 CFR §489, as defined in Appendix A, and (2) under contract with the South Carolina Medicaid program/SCDHHS.

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 barred from participation in the Medicaid and/or Medicare program. ~~Employees and agents must follow all applicable provisions of the South Carolina Insurance regulations regarding accident and health licensure~~. 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 SCDHHS that was terminated, suspended, denied, or not renewed as a result of any action of the CMS of the U.S. Department of Health and Human Services 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 S-CHIP except for emergency services. Failure to adhere to this provision may result in one or more of the following sanctions:

3.1.2.1 SCDHHS may withhold part or all of the capitation payment due on behalf of a Medicaid MCO program member if service is provided or authorized by unlicensed personnel;

3.1.2.2 In the event SCDHHS discovers 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 program members. Upon proper licensing by the appropriate authority and approval by SCDHHS, the Contractor may reinstate the subcontractor to provide services to Medicaid MCO program members.

3.1.2.3 SCDHHS may refer the matter to the appropriate licensing authority for action;

3.1.2.4 SCDHHS may assess liquidated damages as described in §13.3 or impose sanctions as required in §13.5 of this Contract.

3.2 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 as well as the MCO Policy and Procedure Guide and NCQA Standards.

3.2.1 The process for periodic re-credentialing shall be implemented at least every three years. :

3.2.2 If the Contractor has delegated the credentialing to a subcontractor, there shall be a written description of the delegation of credentialing activities within the subcontract. The subcontract must require the subcontractor to provide assurance that all licensed medical professionals are credentialed in accordance with SCDHHS' credentialing requirements. SCDHHS will have final approval of the delegated entity.

3.2.3 The Contractor shall develop and implement policies and procedures for approval of new providers, and termination or suspension of providers.

3.2.4 The Contractor shall develop and implement a mechanism, with DHHS approval, for reporting quality deficiencies which result in suspension or termination of a network provider/subcontractor.

3.2.5 The Contractor shall develop and implement an appeal process, with DHHS approval, for sanctions, suspensions, and terminations imposed by the Contractor against network providers/subcontractors.

3.3 Training

The Contractor shall be responsible for training all of its employees and network providers, and subcontractors to ensure that they adhere to the Medicaid MCO Program policies and procedures and Medicaid regulations. The Contractor shall be responsible for conducting ongoing training on Medicaid MCO Program policies and distribution of updates for its network providers/subcontractors. SCDHHS reserves the right to attend any and all training programs and seminars conducted by the Contractor. The Contractor shall provide SCDHHS a list of any marketing training dates, time and location, at least thirty (30) calendar days prior to the actual date of training.

3.4 Liaisons

The Contractor shall designate an employee of its administrative staff to act as liaison between the Contractor and SCDHHS for the duration of the Contract. SCDHHS's Department 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 SCDHHS when such communication is required.

If different representatives are designated after execution of this Contract, notice of the new representative shall be rendered in writing to the other party **within 30 days of the designation**.

3.5 Material Changes

The Contractor shall notify SCDHHS immediately of 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 provider network, subcontractor network, Contractor's complaint and grievance procedures; health care delivery systems, services, changes to 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. In addition, all changes~~, as required under S.C. Code Ann. §38-33-30(c)(Supp. 2000, as amended),~~ must be approved in writing by SCDHHS and **a** copy of appropriate changes shall be issued to Medicaid MCO Program members prior to implementation of the change as required under S.C. Code Ann § 38-33-30(c)(Supp. 2000, as amended), at least 30 days before the intended effective date of the change. SCDHHS shall make the final determination as to whether a change is material.

The Contractor shall be responsible for all costs associated with any voluntary changes the Contractor makes during the term of this Contract or during Contract termination. Costs associated with any changes may include but are not limited to costs incurred for name changes, for changes to the enhanced benefit file, and by the enrollment broker in updating its system and website to incorporate the changes.

3.6 Incentive Plans

The Contractor's incentive plans or its network providers/subcontractors shall be in compliance with 42 CFR 434 (2005, as amended), 42 CFR 417.479 (2005, as amended), 42 CFR 422.208 and 42 CFR 422.210 (see MCO Policy and Procedure Guide). The Contractor shall submit any information regarding incentives as may be required by SCDHHS.

3.7 Notification of Legal Action

The Contractor shall give SCDHHS immediate notification in writing by certified mail of any administrative legal action or complaint filed and prompt notice of any claim made against the Contractor by a subcontractor or member which may result in litigation related in any way to this Contract with SCDHHS.

3.8 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 arrangement**s** and procedures must include the following:

3.8.1 Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State standards and regulations.

3.8.2 The designation of a compliance officer and a compliance committee that are accountable to senior management.

3.8.3 Effective training and education for the compliance officer and the organization's employees.

3.8.4 Effective lines of communication between the compliance officer and the Contractor's employees, sub-contractors, and providers;

3.8.5 Enforcement of standards through well-publicized disciplinary guidelines.

3.8.6 Provisions for internal monitoring and auditing;

3.8.7 Provision 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 SCDHHS for approval upon ~~initiated~~**initiation** of this contract and then whenever changes occur.

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

3.9 Ownership

The Contractor shall provide SCDHHS with full and complete information on the identity of each person or corporation with an ownership of controlling interest (5%+) in the plan, or any subcontractor in which Contactor has 5% or more ownership interest. This information shall be provided to SCDHHS on the approved Disclosure Form and **updated** whenever changes in ownership occur.

3.10 Excluded Parties

The Contractor shall ~~be responsible for checking~~**check** the Excluded Parties List Service~~, that is~~ 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 significant to the ~~MCE's~~**MCO's** contractual obligation. The Contractor shall also report to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program."

REVISION V

NOW, THEREFORE, 4 SERVICES, as shown in the April 1, 2008 contract, shall be revised and amended and shall now read as follows:

"4 SERVICES

The Contractor shall possess the expertise and resources to ensure the delivery of quality health care services to Medicaid MCO Program 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 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 members and potential members. Decisions for utilization management, member education, coverage of services and other areas to which guidelines apply ~~are~~**should be** consistent with the guidelines.

4.1 Core Benefits For The South Carolina Medicaid MCO Program

Core benefits shall be available to each Medicaid MCO Program 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. The Contractor:

4.1.1 Shall ensure that services are sufficient in amount, duration, or 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 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 Title XIX SC State Medicaid Plan. Services shall be furnished up to the limits as specified in the minimum service requirements outlined in MCO Policy and Procedure Guide. No medical service limitation can be more restrictive than those that currently exist under the Title XIX SC State Medicaid Plan. In the provision of certain maternity services, the Contractor shall provide services in accordance with 42 CFR Part 440 Subpart B. A summary listing of the core benefits is as follows:

Inpatient Hospital Services
Outpatient Services
Physician Services
Maternity Services
Ancillary Medical Services
Transplant-Related Services
Family Planning
Early and Periodic Screening, Diagnosis and Treatment/Well Child Visits
Emergency Medical Services
~~and~~ Communicable Disease Services
Independent Laboratory and X-Ray Services
Durable Medical Equipment
Rebated prescription and over the counter (OTC) drugs
Emergency Transportation
Home Health Services
Institutional Long Term Care Facilities/Nursing Homes, Swing Bed
and Administrative Days (~~First thirty (30) days~~**See MCO Policy and Procedure Guide for specific limitations**)
Psychiatric Assessment Services
Preventive/Rehabilitative Services for Primary Care Enhancement
Outpatient Pediatric Aids Clinic Services
Developmental Evaluation Services
Hearing Aids and Hearing Aid Accessories
Disease Management Services
~~Audiology~~**Audiological Services**
Physical Therapy, Occupational Therapy and Speech Therapy
Chiropractic Services

In the provision of core benefit services outlined and defined in MCO Policy and Procedure Guide, the Contractor shall be required to provide medically necessary and appropriate care to Medicaid MCO program members under this Contract. "Medically necessary" services include, but are not limited to, services directed toward the maintenance, improvement, or protection of health or lessening of illness, disability, or pain. The SCDHHS shall make final interpretation of any disputes about the medical necessity and continuation of core benefits covered under this Contract based on

whether or not the Medicaid fee-for-service program would have provided the service.

The Contractor shall ensure the provision of the core benefits as defined and specified 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 Program member. Information regarding coverage allowance for a non-formulary product shall be disseminated to Medicaid members and providers.

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

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

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service is a comprehensive and preventative child health program for individuals under the age of 21. The program consists of two mutually supportive, operational components: (1) assuring the availability and accessibility of required healthcare services; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources. EPSDT's intent is to direct attention to the importance of preventive health services and early detection and treatment of identified problems. The Contractor shall have written procedures for notification, tracking, and follow-up to ensure these 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.

~~On a monthly basis, SCDHHS will provide the Contractor with immunization data for Medicaid MCO Program members through the month of their twenty first (21st) birthday, who are enrolled in the Contractor's plan. Refer to **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. The Contractor's network providers shall

also report the required immunization data to the State Immunization Information System (SIIS) administered by the SCDHEC. Expenditures for the medical services as previously described have been factored into the capitated rate described in §2.1 of this Contract and the Contractor will not receive any additional payments.

4.3 Emergency Medical Services

The Contractor shall provide that emergency and post-stablization services be rendered without the requirement of prior authorization of any kind; and advise all Medicaid MCO Program 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 which 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 member shall determine when the 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 member's PCP, MCO or applicable State entity of the member's screening and treatment within 10 calendar days of presentation for emergency services. The Contractor shall not deny payment for treatment when a representative of the entity instructs the member to seek emergency services. The Contractor shall not deny payment for treatment obtained when a member had an emergency medical condition and the absence of immediate medical attention would not 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 SSA Section 1867 (42 U.S.C. 1395 dd): 1) Determining if an emergency exists for Medicaid MCO Program members when the medical screening service is performed. 2) Treatment as may be required to stabilize the medical condition, and for 3) Transfer of the individual to another medical facility within SSA Section 1867 (42 U.S.C. 1395 dd) guidelines and other applicable state and federal regulations.

Contractor shall prior approve any services performed after the provider, whether in or out of the network service area, has stabilized the patient. Contractor shall cover services subsequent to stabilization that were: 1) pre-approved by the Contractor, 2) 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 1 hour after the request was made, 3) if Contractor could not be contacted for pre-approval, and 4) if the Contractor and the treating physician cannot reach an agreement concerning the 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 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 have been factored into the capitated rate described in §2.1 of this Contract and the Contractor will not receive any additional payments.

The Contractor shall limit charges to members for any post-stabilization care services to an amount no greater than what the Contractor would charge the 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 member's care, 2) a network physician assumes responsibility for the member's care through transfer, 3) a representative of the Contractor and the treating physician reach an agreement concerning the member's care, or 4) the 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 (2005, as amended). Plan provided, non-elective, medically necessary hysterectomies shall meet the requirements as outlined in MCO Policy and Procedure Guide. Expenditures for the medical services as previously described have been factored into the capitated rate described in § 2.1 of this Contract and the Contractor will not receive any additional payments.

4.5 Sterilization

A sterilization procedure is defined as any medical treatment or procedure that renders an individual permanently incapable of reproducing. Federal regulations contained in 42 CFR 441.250 - 441.259 require that a consent form be completed before a sterilization procedure can be performed. Non-therapeutic sterilizations shall be documented with a completed Consent Form. Sterilization for a male or female must meet the requirements as outlined in MCO Policy and Procedure Guide. Expenditures for the medical services as previously described have been factored into the capitated rate described in § 2.1 of this Contract and the Contractor will not receive any additional payments.

4.6 Limitations on Abortions

The Contractor shall perform abortions in accordance with 42 CFR 441. 200 et seq., 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 (1) physical disorder, injury, or illness including a life-endangering physical condition caused by or arising from the pregnancy itself would, as certified by a physician, place the mother in danger of death unless an abortion is performed; or (2) the pregnancy is the result of an act of rape or incest. Abortions must be prior approved before the service is rendered to ensure compliance with the Federal Regulation. Abortions must be documented with a completed Abortion Statement Form and must meet the requirements as outlined in MCO Policy and Procedure Guide to satisfy state and federal regulations.

The Contractor understands and agrees that SCDHHS shall not make payment to the Contractor for any health benefits coverage under this contract if any abortion performed hereunder violates federal regulations (Hyde Amendment). The term “health benefits coverage” shall mean the package of services covered by the Contractor pursuant to a contract or other arrangement.

4.7 Medical Services for Special Populations

The Contractor shall implement mechanisms to assess each member identified by the State and identified to the Contractor by the State as having special health care needs in order to identify any ongoing special condition of the 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 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. MCO Policy and Procedure Guide outlines the best practices and procedures that the Title XIX SC State Medicaid Plan uses to serve the designated special populations. Expenditures for the health care services of the special populations as previously described have been factored into the capitated rate described in § 2.1 of this Contract and the Contractor will not receive any additional payments.

Children with chronic/complex health care needs and all infants of high risk mothers are defined as special populations in the Title XIX SC State Medicaid 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 services set forth below will continue to be provided/reimbursed by the current Medicaid program as fee-for-service. Refer to the MCO Policy and Procedure Guide for more detailed information on these services.

Institutional Long Term Care Facilities/Nursing Homes – after first 30 days of confinement
Mental Health, Alcohol and Other Drug Abuse Treatment Services
Non-Emergency Transportation
Vision Care
Dental Services
Targeted Case Management Services
Home and Community Based Waiver Services
Pregnancy Prevention Services – Targeted Populations
MAPPS Family Planning Services
Organ Transplantation
School Based Services

4.~~8~~**9** Expanded Services/Benefits

The Contractor may offer expanded services and benefits to enrolled Medicaid MCO Program members in addition to those covered services specified in MCO Policy and Procedure Guide ~~of~~**and** this Contract. These expanded services may include health care services which are currently non-covered services by the Title XIX SC State Medicaid Plan and/or which are in excess of the amount, duration, and scope of those listed in MCO Policy and Procedure Guide. These services/benefits shall be specifically

defined by the Contractor in regard to amount, duration and scope. SCDHHS will not provide any additional reimbursement for these services/benefits. SCDHHS will not provide or pay for member transportation to/from expanded services/benefits. Transportation for these services/benefits is the responsibility of the member and/or Contractor, at the discretion of the Contractor. The Contractor shall provide SCDHHS a description of the expanded services/benefits to be offered by the Contractor for approval, which shall be included and incorporated as a part hereof to the Contract and included in the Contractor's marketing information. Additions, deletions or modifications to expanded services/benefits made during the contract year must be submitted to SCDHHS, for approval, in accordance with requirements listed in the MCO Policy and Procedure Guide.

4.~~9~~**10** Care Coordination

The Contractor shall ensure that each 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 member. The Contractor shall be responsible for the planning, directing and coordinating of health care needs and services for Medicaid MCO Program 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 Members requiring both medical and behavioral health services. These activities must include assessment, scheduling assistance, monitoring and follow-up for its MCO member(s) needing or requiring both medical and behavioral health services.

4.~~9~~**10**.1 Referral System

The Contractor shall provide the coordination necessary for the referral of Medicaid MCO Program members to specialty providers and to out of plan services that may be available through fee-for-service Medicaid providers. ~~Refer to **§12.5** of this Contract and **MCO Policy and Procedure Guide,** SCDHHS Member Listing and Provider Listing Record Layout.~~ The Contractor shall provide SCDHHS a copy of its referral and monitoring process for services included in the core benefits, expanded services, and/or services available through Medicaid fee-for-service. A list of fee-for-service benefits ~~are~~**is** outlined **in §4.8** and defined in **the** MCO Policy and Procedure Guide~~, Services Outside Core Benefits~~. These services will continue to be provided by Medicaid and are consistent with the outline and definition of covered services in the Title XIX SC State Medicaid Plan. Payment for these services will remain fee-for-service, unless the Contractor chooses to offer them as an expanded service.

4.~~9~~**10**.2 Continuity of Care

The Contractor shall develop and maintain effective continuity of care activities which seek to ensure a continuum approach to treating and providing health care services to Medicaid MCO Program 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 seek to provide processes by which Medicaid MCO Program members and network provider interactions can effectively occur and identify and address problems when those interactions are not effective or do not occur.

In order to provide a continuum approach to managing the needs of the member, the Contractor shall provide effective continuity of care activities that seek to ensure that the appropriate personnel, including the Primary Care Provider, are kept informed of the member's treatment needs, changes, progress or problems. The Contractor shall ensure that service delivery is properly monitored to identify and overcome barriers to primary and preventive care that the Medicaid MCO Program member may encounter.

~~The Contractor shall honor any prior authorization for ongoing covered Medicaid services to a Medicaid MCO Program member and reimburse the provider at the current Medicaid fee-for-service rate until the Contractor's primary care provider assigned to that member reviews the member's treatment plan.~~

Unless otherwise required by this contract, the Contractor shall not be obligated to directly furnish or pay for any services outside the core benefits except those included in the expanded services/benefits as stipulated in this Contract. The Contractor shall assist the member in determining the need for services outside the core benefits and refer the member to the appropriate service provider. The Contractor shall establish a process to coordinate the delivery of core benefits with services that are reimbursed fee-for-service by SCDHHS. The Contractor may request the assistance of SCDHHS for the referral to the appropriate service setting.

4.~~9~~**10**.3 Targeted Case Management Services

Targeted Case Management (TCM) services are defined as those services which will assist an individual eligible under the State Plan in gaining access to needed medical, social,

educational and other services. A systematic referral process to service with documented follow-up shall be included. TCM services ensure necessary services are available and accessed for each eligible patient. TCM services are offered to alcohol and substance abuse individuals, children in foster care, chronically mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with mental retardation or a related disability, individuals with 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 targeted case management 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, ensures that the necessary services are available and accessed for each eligible patient. The Contractor shall be responsible for developing a system for coordinating health care for members that require case management services that avoids duplication and ensures that the members needs are adequately met. TCM services available to members are outlined in MCO Policy and Procedure Guide.

SCDHHS 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.~~9~~**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.~~9~~**10**.5 Women, Infant, and Children (WIC) Program Referral

The Contractor shall be responsible for ensuring that coordination exists between the WIC Program and network providers. Coordination shall include referral of potentially eligible women, infants and children and reporting of appropriate medical information to the WIC Program. The South Carolina Department of Health & Environmental Control (DHEC) administers the WIC Program. A sample

referral/release of information form is found in MCO Policy and Procedure Guide, WIC Referral Form.

4.~~9~~**10**.6 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 thirty (30) days of services in any given episode of long-term care/nursing home placement as specified in MCO Policy and Procedure Guide

The Contractor is responsible for notifying SCDHHS of any Medicaid MCO Program members requiring institutionalization in a long term care facility/nursing home. See §10.7 and MCO Policy and Procedure Guide.

Medicaid MCO Program members admitted to a long term care facility/nursing home and requiring institutionalization for more than thirty days (30) will be disenrolled from the Medicaid MCO Program. ~~After the first thirty days (30), payment for services will be billed fee-for-service by the appropriate Medicaid enrolled provider.~~ **The Contractor will be responsible for long term care until the member can be disenrolled at the earliest effective date allowed by system edits, at which time payment for institutional long-term care services will be reimbursed fee-for-service by the Medicaid program.**

4.~~9~~**10**.7 Psychiatric Assessment Services

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

Hospital Services (UB92 claims)
- Inpatient DRGs 424 through 433, 521 through 523
- Outpatient: primary diagnosis has a class code of C

Physician/Clinic (CMS 1500 claims)
- Services provided by the Department of Alcohol and Other Drug Abuse Services (DAODAS)**;**
- Services provided by the Department of Mental Health (DMH)**;**
- Psychiatric services except the assessment codes detailed in MCO Policy and Procedure Guide

All other services that include a mental health or alcohol and other drug abuse diagnosis are included in the managed care rate and shall be paid by the Contractor.

4.~~9~~**10**.8 Coordination of Referral Outside of Core Benefits

The Contractor shall coordinate the referral of members for services that are outside of the required core benefits and which will continue to be provided by enrolled Medicaid providers. These services are consistent with the outline and definition of covered services in the Title XIX SC State Medicaid Plan. These services include, but are not limited to targeted case management services, intensive family treatment services, therapeutic day services for children, out of home therapeutic placement services for children, inpatient psychiatric hospital and residential treatment facility services.

4.~~10~~**11** Family Planning and Communicable Disease Services

4.~~10~~**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 program members as specified in MCO Policy and Procedure Guide. Medicaid MCO program members shall have the freedom to receive family planning services outside the Contractor's provider network by appropriate Medicaid providers without any restrictions. For members who elect to receive family planning services outside the Contractor's provider network, the enrolled Medicaid provider will bill SCDHHS to be reimbursed by SCDHHS fee-for-service. Medicaid MCO program 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 member's total care. No additional reimbursements shall be made to the Contractor for Medicaid MCO program members who elect to receive family planning services through the Contractor's provider network.

4.~~10~~**11**.2 Communicable Disease Services

Communicable disease services are available to help control and prevent diseases such as tuberculosis (TB), sexually transmitted diseases (STD), and Human Immunodeficiency Virus/~~Aquired~~**Acquired** Immune Deficiency Syndrome (HIV/AIDS) infection. The Contractor shall make available communicable disease services to Medicaid MCO program members as specified in MCO Policy and Procedure Guide.

4.~~10~~**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. Sections 44-1-80 through 44-1-140 and Sections 44-29-10 through 44-29-90 by reporting all cases of TB, STD and HIV/AIDS infection to the state public health agency within 24 (twenty-four) hours of notification by provider or from date of service. Refer to the annual issue of "Epi-Notes", the Department of Health and Environmental Control's (DHEC) 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.~~10~~**11**.2.2 Control and Prevention of Communicable Diseases

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, STD, 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.

The Contractor and/or its network provider for clinical management, treatment and direct observed therapy must refer TB suspects and cases to DHEC. This care will be coordinated with the Contractor's PCP.

4.~~10~~**11**.2.3 Patient Confidentiality

The public state health agency 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 Program members who choose diagnosis and treatment for TB, STD and HIV/AIDS infection in the state public health clinics, information regarding their diagnosis and treatment will be provided to the Contractor's primary care provider assigned to that member only with the written consent of the member, unless otherwise provided by law.

4.~~11~~**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 by the Contractor
- The number of network providers who are not accepting new Medicaid patients
- The geographic location of providers and Medicaid members; considering distance travel time, means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.

The Contractor shall provide female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the members 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 member to obtain one outside the network at no cost to the member. If the network is unable to provide necessary services, covered under the contract, to a particular member, the Contractor shall adequately and timely cover these services out of network for the 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 member is no greater than it would be if the services were furnished within the network.

4.~~11~~**12**.1 Service Area

The Contractor shall attach a copy of and describe its service area as approved by the SCDHHS. The Contractor shall attach a copy of and describe its Medicaid service area if different from that approved by SCDHHS. The attachment shall be incorporated herein as part of the Contract. Any changes to the Contractor's service area must be approved by SCDHHS thirty (30) calendar days prior to the effective date of the change.

4.~~11~~**12**.2. Adequacy of Providers

The Contractor shall maintain appropriate levels, as determined by SCDHHS, of organizational components, including, but not limited to primary care providers, specialty providers and other 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 SCDHHS, to ensure that all contracted services are available and accessible in a timely manner within the Contractor's service area in accordance with § 4 and as approved by SCDHHS.

The Contractor shall make available and accessible, as determined by SCDHHS, hospitals, facilities, and professional personnel sufficient to provide the required core benefits.

The locations of facilities, primary care providers, and network providers must be sufficient in terms of geographic convenience to low-income and rural areas.

SCDHHS 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 program member shall be provided in the same manner as those services that are provided to commercial members of the Contractor. The services shall be as accessible to Medicaid MCO program members as they are for non-Medicaid members residing in the same geographic service area.

The Contractor shall notify SCDHHS immediately of any changes to the composition of its provider network and/or subcontractors that materially and adversely affects its ability to make available all core benefits in a timely manner in accordance with § 4 of this Contract. The Contractor shall also have procedures to address changes in its provider network that negatively affect the ability of Medicaid MCO program members to access services. Material changes in provider network composition that are not prior approved by SCDHHS and/or that may impair the Medicaid MCO program member's access to services will be considered as grounds for Contract termination. The Contractor understands and agrees that notwithstanding the execution of this contract, the Contractor nor its subcontractor/network provider shall provide any services to Medicaid MCO program member until the Contractor has an adequate provider network verified and approved by SCDHHS**.**

In the event a MCO's county network(s) is found to be in violation of the requirements stated in this section, SCDHHS shall reserve the right to implement the MCO Provider County Network Termination Transition Plan, as described in the MCO Policy and Procedure Guide.

The Contractor will be responsible for all financial costs associated with termination of its county network(s), including, but not limited to, costs associated with changes to the enrollment broker's website and computer system and any mailings by the enrollment broker and/or SCDHHS to the Contractor's members concerning the termination(s).

SCDHHS may also, in its sole discretion, suspend any new enrollments in the Contractor's plan, including auto-enrollments, in the affected county(ies) during the Transition Plan period or until the Contractor has demonstrated that it will be able to maintain the county network(s).

4.~~11~~**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 it decision. The Contractor shall not be required to maintain specific member-to-specialist provider ratios. The Contractor shall provide adequate access, as determined by SCDHHS, either through employment or subcontracting, to providers for Primary Care Provider (PCP) referrals, Specialty services and/or Ancillary medical services to ensure that these services are available in accordance with § 4 of this Contract.

4.~~11~~**12**.3.1 Primary Care Providers (PCP)

A PCP in the Medicaid MCO Program must be a physician or network provider/subcontractor 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) or outpatient clinic. The Contractor shall agree to provide at least one (1) full time equivalent (FTE) PCP per two thousand five hundred (2,500) members (Medicaid MCO Program members and existing commercial members).

Each Medicaid eligible 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 eligibles who are unable or unwilling to make a choice at the point of completing the enrollment form shall be contacted by the Contractor to assist the member in choosing a PCP. The Contractor shall assign **a** ~~PCPs~~**PCP** to **a** Medicaid ~~members~~**member** if the member fails to select a new PCP within the MCO's established timeframe or after a change in PCP has occurred (i.e. - PCP no longer participating). The Contractor shall submit to SCDHHS a copy of the procedures to be used to contact Medicaid MCO program members for initial member education for approval prior to contract execution. These procedures shall adhere to the enrollment process and procedures outlined in §6 and the post enrollment procedures required in §8 of this Contract.

The PCP selected for the Medicaid MCO program member should be a provider that is located geographically close to the Medicaid MCO program member's home, and/or best meets the needs of the member. However, the Medicaid MCO program member has the freedom to request a change of primary care provider within the time frames and guidelines established by the Contractor. The time frames and guidelines established by the Contractor must not conflict with the Federal rules and regulations governing time frames.

The Contractor shall identify to SCDHHS or its designee monthly any PCP approved to provide services under this Contract who will not accept new patients.

The PCP shall serve as the member's initial and most important point of interaction with Contractor's provider network. The PCP responsibilities shall include, at a minimum:

4.~~11~~**12**.3.1.1 Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;

4.~~11~~**12**.3.1.2 Monitoring 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.~~11~~**12**.3.1.3 Providing the coordination necessary for the referral of patients to specialists and for the referral of patients to services that may be available through fee-for-service Medicaid.

4.~~11~~**12**.3.1.4 Maintaining a medical record of all services rendered by the PCP and other referral providers.

4.~~11~~**12**.4 Specialty Providers

The specialty provider must comply with all applicable statutory and regulatory requirements of the Medicaid program; be eligible to participate in the Medicaid program; and be Board Certified or Admissible.

Specialty Provider responsibilities shall include at a minimum:

4.~~11~~**12**.4.1 Providing consultation summaries or appropriate periodic progress notes to the member's primary care provider on a timely basis, following a referral or routinely scheduled consultative visit;

4.~~11~~**12**.4.2 Notifying the member's primary care provider when scheduling a hospital admission or any other procedure requiring the primary care provider's approval;

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

4.~~11~~**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.~~11~~**12**.6 Hospital Providers

Hospital services 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. ~~Neonates who have received the maximal benefit of specialized care but are not yet ready to be discharged may be transported back to the hospital from which they originated, if appropriate (back transport). In accordance with the **MCO Policy and Procedure Guide**, the hospital that qualifies to receive the reinsurance payment shall determine if the member is to be back transported. If the Contractor is responsible for payment, the MCO shall determine the back transport status.~~

4.~~12~~**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 in the provision of services under this Contract. The SCDHHS 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 there is failure to comply by any provider. At a minimum, this shall include:

4.~~13~~**13.1** Twenty-Four (24) Hour Coverage

The Contractor shall ensure that all emergency medical care is 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 Program members on where to receive emergency and urgent health care.

The Contractor's network provider/subcontractor may elect to provide 24 hour coverage by direct access or through arrangement with a triage system. The triage system arrangement must be prior approved by SCDHHS.

4.13.~~1~~**2** Travel Time and Distance

The Contractor shall ensure that in accordance with usual and customary practices primary care provider 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 member's residence. Exceptions may be made if the travel distance for medical care exceeds thirty (30) miles.

Other medical service providers participating in the Contractor's managed care delivery system also must be geographically accessible to Medicaid MCO Program members, as outlined in the MCO Policy and Procedure Guide.

4.13.~~2~~**3** Scheduling/Appointment Waiting Times

The Contractor shall ensure that its subcontractors/network providers have an appointment system for covered core benefits and/or expanded services which are in accordance with prevailing medical community standards but shall not exceed the following requirements:

4.13.~~2~~**3**.1 Routine visits scheduled within four (4) to six (6) weeks;

4.13.~~2~~**3**.2 Urgent, non-emergency visits within forty-eight (48) hours; ~~and~~

4.13.~~2~~**3**.3 Emergent or emergency visits immediately upon presentation at a service delivery site; **and**

4.13.~~2~~**3**.4 Waiting times should 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 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 Program members requiring specialty health care services.

There must be written evidence of the communication of the patient results/information to the referring physician by the specialty health care provider or continued communication of patient information between the **specialty health care provider and the** primary care provider.

4.15 Cultural Considerations

The Contractor shall promote the delivery of services in a culturally competent manner to all 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 member entering the Contractor's MCO 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 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 member may be reasonably 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 member was enrolled in another MCO or the Medicaid fee-for-service program for a period of thirty (30) calendar days after the member's enrollment in the Contractor's MCO."

REVISION VI

NOW, THEREFORE, 5 SUBCONTRACTS, as shown in the April 1, 2008 Contract shall be revised and amended and shall now read as follows:

"5 SUBCONTRACTS

The Contractor shall provide or assure the provision of all covered services specified in §4 of this Contract. The Contractor may provide these services directly or may enter into subcontracts with providers who will provide services to the members in exchange for payment by the Contractor for services rendered. Subcontracts are required with all providers of services unless otherwise approved by SCDHHS. The Contractor shall remain responsible for all contractual requirements including those performed by the subcontractor(s). Any plan to delegate responsibilities of the Contractor to a subcontractor shall be approved by SCDHHS.

Model subcontracts, for each health care provider type shall be submitted in advance to SCDHHS and shall include a copy of and specify that the subcontractor adhere to the Quality Assessment and Performance Improvement Program (QAPI) Requirements specified by SCDHHS contained in MCO Policy and Procedure Guide, Quality Assessment and Utilization Management Requirements. The Contractor shall submit to SCDHHS for review and approval, prior to execution, any subcontract, that is materially different from the model subcontract for that provider type. The SCDHHS shall have the right to review and approve any and all subcontracts entered into for the provision of any services under this contract.

Notification of amendments or changes to any subcontract which, in accordance with §3.5 of this Contract, materially affects this Contract, shall be provided to SCDHHS prior to the execution of the amendment in accordance with §1.7 of this Contract. The Contractor shall not execute subcontracts with providers who have been excluded from participation in the Medicare and/or Medicaid program pursuant to §§ 1128 (42 U.S.C. 1320a-7) (2001, as amended) or 1156 (42 U.S.C. 1320 c-5) (2001, as amended) of the Social Security Act or who are otherwise barred from participation in the Medicaid and/or Medicare program. The Contractor shall not enter into any relationship (See Appendix A – Definition of Terms) with anyone debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders. In the event of non-renewal of a subcontractor's agreement, the Contractor shall inform SCDHHS of the intent to terminate the subcontract ninety (90) calendar days prior to the effective date of termination of said subcontract. If the Contractor terminates the subcontract for cause, the Contractor shall notify SCDHHS sixty (60) calendar days prior to the termination. If the subcontract is terminated for any material breach, the Contractor shall give the subcontractor thirty (30) calendar days written notice and shall notify SCDHHS of the termination sixty (60) calendar days prior to the termination of said subcontract. The Contractor must make a good faith effort to give written notice of termination of a contracted provider, within fifteen (15) days after receipt of issuance of the termination notice, to each enrollee who received his or her primary care from or was seen on a regular basis by the terminated provider.

5.1 Subcontract Requirements

All subcontracts executed by the Contractor pursuant to this section shall, at a minimum, include the requirements listed below. No other terms or conditions agreed to by the Contractor and subcontractor shall negate or supersede the following requirements. **All subcontracts must:**

5.1.1 Be in writing and signed by the Contractor and subcontractor;

5.1.2 Specify the effective dates of the subcontractor agreement;

5.1.3 Specify in the subcontractor agreement that the subcontractor agreement and its appendices contain all the terms and conditions agreed upon by the parties**;**~~.~~

5.1.4 Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties;

5.1.~~4~~**5** Assure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor agreement without approval of the Contractor;

5.1.~~5~~**6** Specify that the services covered by the subcontractor agreement must be in accordance with the Title XIX SC State Medicaid Plan and require that the subcontractor shall provide these services to members through the last day that the subcontract is in effect~~,~~. ~~a~~**A**ll final Medicaid benefit determinations are within the sole and exclusive authority of SCDHHS or its designee;

5.1.~~6~~**7** Specify that the subcontractor may not refuse to provide medically necessary or covered preventive services to Medicaid MCO program members covered under this Contract for non-medical reasons;

5.1.~~7~~**8** Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the Contractor;

5.1.~~8~~**9** Specify the amount, duration and scope of services to be provided by the subcontractor;

5.1.~~9~~**10** Provide that emergency services be rendered without the requirement of prior authorization of any kind;

5.1.~~10~~**11** **Require that** ~~I~~if the subcontractor performs laboratory services, the subcontractor must meet all applicable state and federal requirements;

5.1.~~11~~**12** Require that an adequate record system be maintained for recording services, service providers, charges, dates and all other commonly accepted information elements for services rendered to members pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness,

and timeliness of services performed under this Contract). Medicaid MCO program members and their representatives shall be given access to and **can** ~~requested~~**request** copies of the members medical records, to the extent and in the manner provided by S.C. Code Ann. §44-115-10 et. seq., (Supp. 2000) as amended and subject to reasonable charges;

5.1.~~12~~**13** Require that any and all member records—financial, medical, etc.—be retained for a period of ~~three~~**five** (~~3~~**5**) years after the last payment was made for services provided to a member and retained further if the records are under review or audit until the review or audit is complete. This requirement pertains to the retention of records for Medicaid purposes only; other state or federal rules may require longer retention periods. Current State law (S.C**.** ~~ST SEC~~ **Code Ann. §**44-115-120) requires physicians to retain their records for at least ten (10) years for adult patients and at least thirteen (13) years for minors. These minimum record keeping periods begin to run from the last date of treatment. After these minimum record-keeping periods, state law allows for the destruction of records. Said records shall be made available for fiscal audit, medical audit, medical review, utilization review, and other periodic monitoring upon request of **an** authorized representative of SCDHHS.

5.1.~~13~~**14** Provide that SCDHHS, U.S. Department of Health and Human Services (HHS), CMS, Office of Inspector General Comptroller, State Auditor's Office, and the South Carolina Attorney General's Office shall have the right to evaluate through **audit** inspection, or other means, whether announced or unannounced, any records pertinent to this Contract**,** including quality, appropriateness and timeliness of services **and the timeliness and accuracy of encounter data and practitioner claims submitted to the Contractor.** ~~and~~ ~~s~~**S**uch evaluation, and when performed, shall be performed with the cooperation of the Contractor. Upon request, the Contractor shall assist in such reviews;

5.1.~~14~~**15** Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the Contractor and/or SCDHHS or its designee;

5.1.~~15~~**16** Specify that the subcontractor shall monitor the quality of services delivered under the agreement and initiate **a** plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Contractor/subcontractor practices and/or the standards established by SCDHHS or its designee;

5.1.~~16~~**17** Require that the subcontractor comply with **any** plan of correction initiated by the Contractor and/or required by SCDHHS;

5.1.~~17~~**18** Provide for submission of all reports and clinical information required by the Contractor, including EPSDT (if applicable);

5.1.~~18~~**19** Require safeguarding of information about Medicaid MCO program members according to applicable state and federal laws and regulations and as described in §13.22 and §13.29 and of this Contract;

5.1.~~19~~**20** Provide the name and address of the official payee to whom payment shall be made;

5.1.~~20~~**21** Make full disclosure of the method and amount of compensation or other consideration to be received from the Contractor;

5.1.~~21~~**22** Provide for prompt submission of information needed to make payment;

5.1.~~22~~**23** **Provide that** ~~T~~the Contractor shall pay 90% of all clean claims from practitioners, either in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt. The Contractor shall pay 99% of all clean claims from practitioners, either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt. The date of receipt is the date the 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, establish an alternative payment schedule. Any alternative schedule must be stipulated in the contract.

5.1.24 Provide that subcontractors must submit all claims for payment no later than twelve (12) months from the date of service.

5.1.~~23~~**25** Specify that the subcontractor shall accept payment made by the Contractor as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the member. Member shall include the patient, parent(s), guardian, spouse or any other legally responsible person of the member being served;

5.1.~~24~~**26** Specify that at all times during the term of the agreement, the subcontractor shall indemnify and hold SCDHHS harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Contract between SCDHHS and the Contractor, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by

incorporating §13.26 of this Contract in its entirety in the subcontractor's agreement or by use of other language developed by the Contractor and approved by SCDHHS. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by SCDHHS.

5.1.~~25~~**27** Require the subcontractor to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the plan's members and the Contractor under the agreement. The subcontractor shall provide such insurance coverage at all times during the agreement and upon execution of the subcontract agreement**, shall** furnish the Contractor with written verification of the existence of such coverage;

5.1.~~26~~**28** Specify that the subcontractor agrees to recognize and abide by all state and federal laws, regulations and guidelines applicable to the provision of services under the Medicaid MCO Program;

5.1.~~27~~**29** Provide that the agreement incorporates by reference all applicable federal and state laws or regulations, and revisions of such laws or regulations shall automatically be incorporated into the agreement as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the Contractor and subcontractor agree to negotiate such further amendments as may be necessary to correct any inequities;

5.1.~~28~~**30** Specify procedures and criteria for any alterations, variations, modifications, waivers, extension**s** of the agreement termination date, or early termination of the agreement and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the agreement;

5.1.~~29~~**31** Specify that the Contractor and subcontractor recognize that in the event of termination of this Contract between the Contractor and SCDHHS for any of the reasons described in this Contract, the Contractor shall immediately make available, to SCDHHS, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the Contractor's and subcontractor's activities undertaken pursuant to the Contractor/subcontractor agreement. The provision of such records shall be at no expense to SCDHHS;

5.1.~~30~~**32** **Provide** ~~T~~**t**hat the Contractor and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt

or interfere with the provisions of services to the Medicaid MCO program member;

5.1.~~31~~**33** Include a conflict of interest clause as stated in §13.34 of this Contract between the Contractor and SCDHHS;

5.1.~~32~~**34** Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement and Utilization Management (UM) requirements as outlined in MCO Policy and Procedure Guide. The QAPI and UM Requirements shall be included as part of the subcontract between the Contractor and the subcontractor;

5.1.~~33~~**35** **Provide that** ~~A~~**a**ll subcontractors shall give the Contractor immediate notification in writing by certified mail of any administrative legal action or complaint filed and prompt notice of any claim made against subcontractor by a subcontractor, or member which may result in litigation related in any way to this Contract with SCDHHS. The Contractor shall assure that all responsibilities related to the subcontract are performed in accordance with the terms of this Contract;

5.1.~~34~~**36** Contain no provision which provides incentives, monetary or otherwise, for the withholding of medically necessary care. See MCO Policy and Procedure Guide, Incentive Plans;

5.1.~~35~~**37** Specify that the subcontractor shall not assign any of its duties and/or responsibilities under this Contract without the prior written consent of the Contractor;

5.1.~~36~~**38** Specify that hospital subcontracts shall require that the hospitals notify the Contractor and SCDHHS of the births when the mother is a member of the Contractor's plan. The subcontract shall also specify that the hospital is responsible for completing SCDHHS Request for Medicaid ID Number (Form 1716 ME), including indicating whether the mother is a member of an MCO, and submitting the form to the local SCDHHS/state SCDHHS office~~.~~**;**

5.1.~~37~~**39** For any subcontract with an FQHC/RHC, the Contractor shall adhere to federal requirements for reimbursement for FQHC/RHC services. The subcontract shall specify the agreed upon payment from the Contractor to the FQHC/RHC. Any bonus or incentive arrangements made to the FQHCs/RHCs associated with Medicaid MCO members must also be specified to SCDHHS. The subcontract shall specify that the Contractor shall submit the name of each FQHC/RHC and the number of Medicaid encounters paid to each FQHC/RHC by month of services to the SCDHHS for ~~reasonable cost based~~**State Plan required**

reconciliation purposes. This information shall be submitted in the format required by SCDHHS **as contained in the MCO Policy and Procedure Guide**.

5.1.~~38~~**40** Specify that Contractor shall not prohibit or otherwise restrict a network provider/subcontractor from advising a member about the health status of the member or medical care or treatment for the member's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the network provider/subcontractor is acting within the lawful scope of practice.

5.1.~~39~~**41** **Provide that** ~~T~~**t**he 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 if the services were furnished by **a** provider which is not an FQHC or RHC.

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

5.1.~~40~~**43** **Provide that** ~~I~~in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), the Provider 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 agreement.

5.1.~~41~~**44** Contain no provision which restricts a network provider/subcontractor from contracting with another Managed Care Organization or other managed care entity."

5.1.45 Provide that all records originated or prepared in connection with the subcontractor'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 subcontractor in accordance with the terms and conditions of this Contract. The contract must further provide that the subcontractor agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of members relating to the delivery of care or service under this Contract, and as further required by SCDHHS, for a period of five (5) years from the expiration date of the Contract, including any Contract

extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five (5) year period, whichever is later. If the subcontractor stores records on microfilm or microfiche, the subcontractor must agree to produce, at its expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request.

5.1.46 For hospital subcontracts, contain a provision that the hospitals must notify the Contractor and SCDHHS of the births when the mother is a member of the Contractor's plan. The subcontract shall also specify that the hospital is responsible for completing SCDHHS Request for Medicaid ID Number (Form 1716 ME) and submitting it to the local SCDHHS/state SCDHHS office

5.1.47 Where the Contractor has entered into capitated reimbursement arrangements with providers, require submission of all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims.

REVISION VII

NOW, THEREFORE, 6 EDUCATION, SELECTION AND ENROLLMENT PROCESS, as shown in the April 1, 2008 Contract, shall be revised and amended and shall read as follows:

"6 EDUCATION, SELECTION AND ENROLLMENT PROCESS

The South Carolina Department of Health and Human Services (SCDHHS) determines eligibility for Medicaid for all coverage groups except for Supplemental Security Income (SSI). The Social Security Administration (SSA) determines eligibility for SSI. Once an applicant is determined eligible for Medicaid by SCDHHS or SSA, the pertinent eligibility information is entered in the Medicaid Eligibility Determination System (MEDS). The rights afforded to potential MCO members are detailed in MCO Policy and Procedure Guide, Members' Bill of Rights.

6.1 Enrolling Eligibles in the Contractor's Plan

If an eligible is enrolled in a managed care program, the SCDHHS will enter the enrollment information as provided in §6.2 of this Contract. SCDHHS will provide the Contractor notification of the Medicaid eligibles who are enrolled, re-enrolled, or disenrolled from their managed care plan, as specified in §6.9. The Contractor shall contact the members as required in §8 of this Contract.

The Contractor shall not discriminate against Medicaid MCO program 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 plan. The Contractor shall provide services to all eligible Medicaid MCO program members who enroll in the Contractor's plan.

6.2 Enrollment Period

The Medicaid MCO program members shall be enrolled for a period of twelve (12) months contingent upon their continued Medicaid eligibility. The member may request disenrollment **once**, without cause**,** at any time during the 90 days following the date of the member's initial enrollment **or re-enrollment** with the MCO. A member shall remain in the Contractor's plan unless the member submits a written**, electronic** or oral request to disenroll, ~~to change~~ **transfer to another** managed care ~~plans~~**plan** for cause or ~~unless~~ the member becomes ineligible for Medicaid and/or MCO enrollment. ~~Oral requests to disenroll shall be confirmed in writing by SCDHHS. If a member's request to disenroll is not acted on within sixty (60) days, it shall be considered approved. The following are considered cause for disenrollment by the member~~:

- ~~The member moves out of the MCO's service area;~~
- ~~The plan does not, because of moral or religious objections, cover the service the member seeks;~~
- ~~The 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 network; and the member's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; and~~
- ~~Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.~~

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

A Medicaid MCO program 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 Contractor's plan**~~and submits a new enrollment form and becomes enrolled in the Contractor's plan within sixty (60) calendar days from the effective date of disenrollment may re-enroll with the Contractor's plan without going through the education process again~~. **Depending on the date eligibility is regained, there may be a gap on the member's MCO coverage. If Medicaid eligibility is regained after 60 days, the reinstatement of Medicaid eligibility will prompt the SCDHHS Enrollment Broker to mail an enrollment packet to the beneficiary. The beneficiary may also initiate the re-enrollment process without an enrollment packet.** See §6.7 for additional information on re-enrollment.

6.3 ~~Effective Date of Enrollment~~ **Selection or Assignment of a Primary Care Provider (PCP)**

~~For a period of time during the effective dates of this contract, SCDHHS will operate its enrollment system under one of the following procedures. If the enrollment broker is operating in a county, the Contractor may not enroll members. This process will be conducted by SCDHHS and the enrollment broker. If the enrollment broker is not operating in a county, the Contractor can enroll members and send that information to SCDHHS for review and processing. The SCDHHS will enter all enrollment information and updates within three (3) working days of receipt of a processable enrollment form. A processable enrollment form is one that does not need to be returned to the recipient for further information and one that passes front end edits when keyed. (Examples of front end edits include, but are not limited to: Recipient Medicaid number must be valid; recipient must be eligible for Medicaid; and recipient cannot be enrolled in a Medicaid Home and Community Based Waiver; and for MCO generated enrollment forms, the recipient has been notified by DHHS of all Medicaid options and 14 days has elapsed from the date on the DHHS notification letter.)~~ The Contractor shall contact the Medicaid MCO member to assist the member in making a selection of a PCP, if a valid PCP is not selected at time of enrollment. The Contractor shall inform the member that each family member has the right to choose his/her own PCP. The Contractor may explain the advantages of selecting the same primary care provider for all family members, as appropriate. The Contractor or SCDHHS shall confirm the PCP selection information in a written notice to the member~~, depending on the status of the enrollment broker in the county~~.

6.4 Enrollment of Newborns

All newborns of Medicaid MCO program members**, where the newborn resides in the same household as the mother,** are the responsibility of the Contractor~~, unless the mother has specified~~

~~otherwise prior to delivery.~~ **A newborn is defined as a Medicaid eligible beneficiary who is under 365 days of age.** To assure continuity of care in the crucial first months of the newborn's life, every effort shall be made by ~~the Contractor~~**SCDHHS** to expedite enrollment of newborns into the Contractor's Plan. ~~For Medicaid MCO Program members, the SCDHHS will enroll newborns into the same managed care plan as the mother, for the first ninety (90) calendar days from birth unless otherwise specified by the mother. The newborn will be enrolled in the same managed care plan as the mother through the end of the month in which the ninetieth (90th) day falls. The newborn's effective date will be the first day of the month of birth. The enrollment form will contain a statement that the member understands that a child born into the family unit will be enrolled in the same MCO as the mother unless otherwise specified by the mother. The newborn shall continue to be enrolled with the mother's MCO unless the mother/guardian changes the enrollment. For retro newborns, a break in a newborn's enrollment could occur between the end of the required 90 days and the next period of enrollment in the Managed Care Plan. This break in enrollment is determined by the date of notification of the newborn to SCDHHS or the date of the creation of the newborn's eligibility record in MEDS.~~

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

~~6.4.1 All hospital subcontracts entered into by the Contractor shall meet the requirements as outlined in **§ 5** of this Contract. In addition, such subcontracts shall require that the hospitals notify the Contractor and SCDHHS of the births when the mother is a member of the Contractor's plan. The subcontract shall also specify that the hospital is responsible for completing SCDHHS Request for Medicaid ID Number (Form 1716 ME) and submitting them to the local SCDHHS/state SCDHHS office.~~

~~6.4.2 The Contractor's hospital subcontractor must notify SCDHHS of the newborn's birth through completion of the Request for Medicaid ID Number Form 1716 ME. A sample form is in **MCO Policy and Procedure Guide** of this contract. This must be completed according to the instructions indicated on the form.~~

~~6.4.3 SCDHHS will add the newborn to the Medicaid eligibility files and return a notice to the hospital confirming the newborn's eligibility and providing the newborn's Medicaid Identification number.~~

~~6.4.4 Any other newborns determined by the Contractor to be Medicaid MCO program members for which the Contractor has not received SCDHHS confirmation, may be enrolled by submitting the SCDHHS Request for Medicaid ID Number~~

~~(Form 1716 ME) to SCDHHS. See **MCO Policy and Procedure Guide**.~~

~~6.4.5 The Contractor shall inform the hospital and the newborn's attending and consulting physicians that the newborn is a Contractor member and that they must seek reimbursement from the Contractor.~~

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

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 person responsible for 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 plan will occur if the newborn's mother was enrolled in the Contractor's Plan during the birth month. The newborn will remain in the Contractor's Plan for the remainder of the year unless the mother changed MCO plans during the second or third month of the newborn's life. If the aforementioned transfer occurred for the mother, the newborn will be transferred to the mother's MCO health plan for the remainder of the first year in managed care. If the mother transfers out of an MCO health plan (to an MHN or to fee-for-service Medicaid), the newborn will not be transferred out of the Contractor's 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 members are eligible for enrollment in the next available assignment period. If the mother is, or will be in an MCO health plan in this next assignment period, the newborn will be assigned to the same plan as the mother. See the MCO Policy and Procedure Guide for additional information concerning enrollment policy.

6.4.~~6~~**5** The Contractor shall reimburse the SCDHHS for any newborn members' fee-for-service claims that the SCDHHS has paid for services included in the core benefits that occurred for any month that a premium or capitated payment was made to the Contractor.

6.4.~~7~~**6** The Contractor shall comply with S. C. Code Ann.§ 38-71-140 (Supp. 2000, as amended) of the South Carolina Insurance Laws pertaining to coverage for newborns and children for whom adoption proceedings have been instituted or completed. SCDHHS will be responsible for paying the required capitated payment only for children who are Medicaid eligible.

6.5 ~~Member Initiated Disenrollment and Change of Managed Care Plans~~**Contractor Follow Up of Voluntary Disenrollees**

The Contractor may conduct an initial follow up for all voluntary disenrollees. These members will be identified on the member listing file with a special indicator. SCDHHS will provide the Contractor with a member listing file (enrollments and disenrollments). The Contractor may contact the member upon receipt of the member listing file. However, follow up must be within the guidelines outlined in MCO Policy and Procedure Guide, Marketing, Member Education and Enrollment. ~~Should the member choose to enroll or re-enroll in a MCO, the enrollment process specific to that county shall apply. The effective date of enrollment will be as specified in section **6.3** of the contract.~~

6.6 Member Initiated Disenrollment and Change of Managed Care Plans

A member may request disenrollment from the MCO as follows:

- **For cause, at any time.**
- **Without cause, at the following times:**
  - **During the 90 days following the members initial enrollment or re-enrollment with the MCO. This is the Member Choice Period.**
  - **At least once every 12 months thereafter.**

All member initiated disenrollment requests must be made to South Carolina Healthy Connections Choices (SCHCC), the SCDHHS's Enrollment Broker.

A 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 member filed the request. If not, the request shall be considered approved.

6.6.1 Member Choice Period

A member may request disenrollment once, without cause, at any time during the 90 days following the date of the member's initial enrollment or re-enrollment with

the MCO. The request must be made to SCHCC and may be verbal, written or electronic.

6.6.2 Member Disenrollment For Cause

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

The following are considered cause for disenrollment by the member:

- **The member moves out of the MCO's service area;**
- **The plan does not, because of moral or religious objections, cover the service the member seeks;**
- **The 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 network; and the member's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk; and**
- **Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.**

6.~~6~~**7** Contractor Initiated Member Disenrollment of Participation

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

- Contractor ceases participation in the Medicaid MCO ~~p~~**P**rogram or in the Medicaid MCO program member's service area;
- ~~Medicaid MCO program m~~**M**ember dies;
- **Member** ~~B~~**b**ecomes an inmate (see Appendix A – Definition of Terms) of a Public Institution;
- **Member** ~~M~~**m**oves out of ~~S~~**s**tate;
- **Member** ~~E~~**e**lects ~~H~~**h**ospice;
- **Member** ~~B~~**b**ecomes ~~I~~**i**nstitutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;
- **Member** ~~E~~**e**lects Home and Community Based Waiver Programs;
- ~~Enters the Medically Fragile Children's Program;~~
- **Member** ~~B~~**b**ecomes age 65 or older; ~~and~~**or**
- **Member** ~~F~~**f**ails to follow the rules of the managed care plan.

The Contractor's request for member disenrollment must be made in writing to SCDHHS using the SCDHHS **Plan Initiated Disenrollment** Form ~~280-2 (10/06)~~ in MCO Policy and Procedure Guide and the request must state the detailed reason for disenrollment. SCDHHS will determine if the Contractor has shown good cause to disenroll the member and SCDHHS will give written notification to the Contractor and the member of its decision. The Contractor and the member shall have the right to appeal any adverse decision.

The Contractor ~~shall not terminate a member's enrollment because of any adverse change in the member's health except when the member's continued enrollment in the Plan seriously impairs the Contractor's ability to furnish services to either this particular member or other members.~~ **may not request disenrollment because of an adverse change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the Plan seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees)**.

If the Contractor ceases participation in the eligible's service area or ceases participation in the Medicaid MCO program, the Contractor shall notify SCDHHS in accordance with the termination procedures in §13.2.10 of this Contract. SCDHHS will notify MCO program members and offer them the choice of another managed care plan in their service area. If there are no other managed care options, they will ~~remain on~~ **be placed in** regular Medicaid. The Contractor shall assist the SCDHHS in transitioning Medicaid MCO program members to another managed care plan or to the Medicaid fee-for-service delivery system to ensure access to needed health care services.

6.~~7~~**8** SCDHHS Initiated Member Disenrollment

The SCDHHS will notify the Contractor of the member's disenrollment due to the following reasons:

- Loss of Medicaid eligibility or loss of Medicaid MCO program eligibility;
- Death of a Member;
- **Member's** ~~I~~**i**ntentional ~~S~~**s**ubmission of ~~F~~**f**raudulent ~~I~~**i**nformation;
- **Member** ~~B~~**b**ecomes an inmate (see Appendix A – Definition of Terms) of a Public Institution;
- **Member** ~~M~~**m**oves out of ~~S~~**s**tate;
- **Member** ~~E~~**e**lects ~~H~~**h**ospice;
- **Member becomes** Medicare ~~Eligibleility;~~ **Eligible**;
- **Member** ~~B~~**b**ecomes institutionalized in a Long Term Care Facility/Nursing Home for more than thirty (30) days;

- **Member** ~~E~~**e**lects Home and Community Based Waiver Programs;
- ~~Enters the Medically Fragile Children's Program;~~
- Loss of Contractor's Participation;
- **Member** ~~B~~**b**ecomes age 65 or older;
- **Member** ~~Enrollment~~ **enrolls** in another MCO through third party coverage; or
- ~~Enrollment in another Medicaid managed care plan~~

The Contractor shall immediately notify SCDHHS when it obtains knowledge of any Medicaid MCO program member whose enrollment should be terminated prior to SCDHHS' knowledge. See MCO Policy and Procedure Guide.

~~The Contractor shall have the right to contact MCO members who have been disenrolled when the reason for disenrollment is "ineligible for Medicaid". This means that Medicaid eligibility has been terminated. These members will be identified on the member listing file with a special indicator. The Contractor may contact the member upon receipt of the monthly member listing file to assist the member in taking any possible actions to continue or regain eligibility. If the member regains Medicaid eligibility, within 60 days of the disenrollment date, the member will be automatically re-enrolled with the Contractor. If eligibility is regained after 60 days of the disenrollment date, the member will need to contact SCDHHS to initiate re-enrollment.~~

~~Automatic re-enrollment will only occur in cases where the Medicaid MCO Program Member has not submitted a written request to disenroll from the Contractor's plan.~~

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

6.~~8~~**9** Notification of Membership to Managed Care Plan

SCDHHS will notify each Contractor at specified times each month of the Medicaid eligibles who are enrolled, re-enrolled, or disenrolled from their managed care plan for the following month. The Contractor will receive this notification through electronic media. See MCO Policy and Procedure Guide for record layout.

SCDHHS 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 SCDHHS and the Contractor, regarding

enrollment, disenrollment and/or termination, SCDHHS will be responsible for taking the appropriate action for resolution.

6.~~9~~**10** Toll Free Telephone Number

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

6.~~10~~**11** Tracking Slot Availability

The Contractor shall identify the maximum number of Medicaid MCO Program members it is able to enroll and maintain under this Contract prior to initial enrollment of Medicaid eligibles. The Contractor shall accept Medicaid eligibles as Medicaid MCO program members in the order in which they apply as determined by SCDHHS up to the limits specified in MCO Policy and Procedure Guide, Required Submissions. The Contractor agrees to provide services to Medicaid MCO program members up to the maximum enrollment limits indicated ~~by~~**for** the Contractor in MCO Policy and Procedure Guide. SCDHHS reserves the right to approve or deny the maximum number of Medicaid MCO program members to be enrolled in the Contractor's plan based on SCDHHS' determination of the adequacy of network capacity.

On a monthly basis consistent with the MCO Policy and Procedures Guide, Contractor is to update the maximum enrollment by county. The Contractor shall track slot availability and notify SCDHHS' **Enrollment Broker** when filled slots are near capacity. Upon notification, SCDHHS or its designee will not assign any other eligibles to that plan without consulting the Contractor first.

The SCDHHS will notify the Contractor when the Contractor's enrollment levels are maximized and **will** not enroll eligibles when there are no more slots available.

6.~~11~~**12** Billing and Reconciliation

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

REVISION VIII

NOW, THEREFORE, 7 MARKETING, as shown in the April 1, 2008 contract, shall be revised and amended and shall now read as follows:

“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, S.C. Medicaid MCO Program or Title XIX, and is targeted in anyway toward Medicaid eligibles for the sole purpose of providing information regarding the contractor’s plan. Activities involving distribution and completion of the MCO enrollment form during the course of marketing activities is an enrollment function and is considered separate and distinct from marketing.

Under the S.C. Medicaid MCO Program, all direct marketing to eligibles or potential eligibles will be performed by SCDHHS or its designee. The Contractor shall not market directly to Medicaid applicants/recipients (including direct mail advertising, door-to-door, telephonic, or other “cold call” marketing). The Contractor shall not ~~implement any marketing activities relative to this Contract without making full disclosure to and obtaining prior written approval from SCDHHS or its designee for each event.~~**sponsor or attend any marketing activities without notifying SCDHHS. All marketing and educational materials must be approved by SCDHHS prior to use. All marketing/advertising and member education activities must comply with instructions as specified in the MCO Policy and Procedure Guide**.

SCDHHS may impose sanctions against the Contractor if SCDHHS determines that the Contractor distributed directly/indirectly or through any agent or independent contractor marketing materials and/or MCO enrollment forms in violation of federal law.

7.1 Information Provided for Enrollment Process

The Contractor shall provide each member with clear, accurate and truthful information about the Contractor's health plan to ensure compliance with this Contract and with state and federal laws and regulations. The Contractor shall ascertain whether the beneficiary has a Primary Care Physician and if so, whether their PCP is a member of the MCO network. The Contractor shall be responsible for developing and distributing its own member specific marketing, educational and enrollment materials including but not limited to, evidence of coverage, member handbook, other materials designed for 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 SCDHHS. 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 Plan by a Medicaid applicant/eligible shall be voluntary. The Contractor shall inform the members that enrollment shall be for a period of twelve (12) months contingent upon their

continued Medicaid eligibility and that the member may request disenrollment **once,** without cause at any time during the 90 days following the date of the member's initial enrollment with the MCO. During marketing presentations, the Contractor must ask female recipients the name of the OB/GYN doctor they are currently using. The Contractor must inform the recipient whether the doctor is a member of the Contractor's provider network. If the doctor is not a member of the Contractor's provider network, the recipient 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 SC Medicaid MCO Program. The Contractor shall describe the marketing activities it will undertake during the Contract period. The Contractor's marketing plan shall take into consideration the projected enrollment levels. The Contractor shall ~~obtain prior approval from~~**notify** SCDHHS of **their participation in** each community event designed to increase community awareness of their participation in the Medicaid MCO Program. ~~At such events, the Contractor may be allowed to present enrollment materials and perform direct enrollment activities~~.

Enrollment activities by the contractor are specifically prohibited ~~in counties where the enrollment broker is performing that function~~. Only written materials describing the Contractor's plan, as approved by SCDHHS, can be distributed at such events. All marketing activities shall comply with MCO Policy and Procedure Guide and this Contract.

Materials used for the purpose of marketing to Medicaid MCO program members must be prior approved by SCDHHS and meet the standards for marketing materials outlined in 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 members to make an informed choice of managed care plans. The Contractor is prohibited from offering or giving any form of compensation or reward as an inducement to enroll in the Contractor's plan.

7.3 Approval of Marketing Plan and Materials

The Contractor shall submit to SCDHHS or its designee all marketing plans and written materials directed at Medicaid eligibles or potential eligibles for approval. These materials include, but are not limited to, materials produced for marketing, member education, evidence of coverage, member handbook and grievance

procedures. Marketing materials include all types of media including brochures, leaflets, newspapers, magazines, radio, television, billboard and yellow page advertisements directed at Medicaid eligibles or potential eligibles. They also include internet-based materials.

~~7.4 MCO Enrollment Form~~

~~For non-enrollment broker counties, the Contractor shall use the SCDHHS approved MCO enrollment form to enroll Medicaid recipients choosing to enroll in the MCO program. The Contractor shall assure that all required fields on the enrollment form are completed prior to submitting them to SCDHHS. Upon receipt of the signed and processable enrollment form, SCDHHS will mail the Medicaid recipient a notice indicating their choice to enroll in the MCO and provide information regarding all Medicaid options. SCDHHS will enroll the Medicaid recipient in the MCO of choice. SCDHHS will monitor the enrollment forms submitted by MCOs for percent of accuracy, completeness and validity. In counties where the enrollment broker is operational, the Contractor may not enroll members. Only SCDHHS and/or its enrollment broker may enroll recipients. The following methods will be accepted by the enrollment broker: 1) telephone, 2) mail, or fax, 3) enrollment broker website, and 4) in person at the recipient's county of residence. The Medicaid recipient can change their decision to enroll in an MCO at any time during the 90 days following the date of the member's initial enrollment with the MCO by using procedures detailed in the **MCO Policy and Procedure** Guide.~~"

REVISION IX

NOW, THEREFORE, 8. POST ENROLLMENT PROCESS, as shown in the April 1, 2008 contract shall be revised and amended and shall now read as follows:

"8 POST ENROLLMENT PROCESS

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

8.1 Member Identification Card

The Contractor shall issue an identification card (ID) within fourteen (14) calendar days of the members' selection of a PCP or receipt of data from SCDHHS, whichever is later. To ensure immediate access to services, the Contractor's providers shall be instructed by the Contractor to accept the member's Medicaid ID Card as proof of enrollment in the Contractor's plan until the member receives its MCO ID card from the Contractor. A list of required ID card

information is outlined in MCO Policy and Procedure Guide. The holder of the member identification card issued by the Contractor shall be a Medicaid MCO program member or guardian of **a** member. If the Contractor has knowledge of any Medicaid MCO program member permitting the use of this identification card by any other person, the Contractor shall immediately report this violation to SCDHHS or its designee. The Contractor shall also insure that its subcontractor**s**/network providers can identify members, in a manner which will not result in discrimination against the members**,** in order to provide or coordinate the provision of all core benefits and/or expanded services and out of plan services.

8.2 Member Services Availability

The Contractor shall maintain an organized, integrated member/patient services function, to be operated during regular business hours, within the plan to assist members in selection of a primary care provider, provide explanation of the Contractor's policies and procedures, (re: access and availability of health services) provide additional information about the primary care providers and/or specialist(s), facilitate referrals to participating specialist, and assist in the resolution of service and/or medical delivery problems and 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 be required to provide prior authorization/access and information on~~f~~ services during evenings and weekends.

8.3 Member Education

The Contractor shall educate members regarding the appropriate utilization of services; access to out-of-plan care, emergency care (in or out of area); and the process for prior authorization of services. Such education shall be provided no later than fourteen (14) calendar days from receipt of enrollment data from SCDHHS or its designee, and as needed thereafter. The Contractor shall identify and educate members who access the system inappropriately and provide continuing education as needed.

The Contractor shall be responsible for reminding pregnant members that their newborn will be automatically enrolled for the ~~first ninety (90) calendar days from birth unless the mother indicates otherwise prior to delivery~~**birth month and the mother may choose to enroll the newborn into another 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, then materials must be made available in that specific language to assure a reasonable chance for all members to understand how to access the plan and use services appropriately.

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

The Contractor shall coordinate with SCDHHS or its designee member education activities as outlined in MCO Policy and Procedure Guide to meet the health care educational needs of the Medicaid MCO program members.

The Contractor shall not discriminate against Medicaid ~~MCO~~**plan** 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 plan.

~~8.3.1 Enrollment Materials~~

~~The Contractor's written enrollment materials shall be governed by the requirements and limitations described in **MCO Policy and Procedure Guide**. The enrollment materials must be approved by SCDHHS or its designee prior to distribution or use by the Contractor. All materials shall be written at a grade level no higher than fourth grade, "or as determined appropriate by SCDHHS", and contain the minimum information as outlined in the **MCO Policy and Procedure Guide**.~~

8.3.~~2~~**1** Member Handbook

The Contractor shall provide each member with a member handbook and other written materials information. The member handbook shall be written at a reading comprehension level no higher than fourth (4th) grade and shall contain the minimum information as outlined in MCO Policy and Procedure Guide and shall be approved by SCDHHS prior to contract execution and initial member enrollment.

8.4 Member's Rights and Responsibilities

The Contractor shall furnish Medicaid MCO program members with both verbal and written information about the nature and extent of their rights and responsibilities as a member of the Contractor's plan. The rights afforded to current members are detailed in MCO Policy and Procedure Guide, Members' Bill of Rights**.** The written information shall be written at a reading comprehension level no higher than fourth (4th) grade, "or as determined appropriate by SCDHHS." The minimum information shall include: the member's

rights to receive written information about the Contractor's managed care plan including information on the structure and operation of the Plan; the network providers/subcontractors providing the member's health care; information about how to obtain benefits; ~~confidentially~~**confidentiality** of patient information; the right to file grievance**s** or complaints about the Contractor and/or care provided; information regarding advance directives as described in 42 CFR 417.436 (2006, as amended) and 42 CFR 489, Subpart I (2006, as amended) and any information that affects the member's enrollment into the Contractor's 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 90 days after the effective date of the change. The Contractor shall provide the member written evidence of coverage.

The Medicaid MCO program members responsibilities shall include but are not limited to: informing the Contractor of the loss or theft of their ID card; presenting their ID card when using health care services; ~~to be~~**being** familiar with the plans procedures to the best of the member's abilities; ~~and/or to call~~**calling** or ~~contact~~**contacting** the Contractor to obtain information and have questions clarified; ~~to provide~~**providing** participating network providers with accurate and complete medical information; ~~follow~~**following** the prescribed treatment of care recommended by the provider or ~~let~~**letting** the provider know the reasons the treatment cannot be followed, as soon as possible; ~~and make~~**making** every effort to keep any agreed upon appointments, and follow-up appointments**;** and ~~to access~~**accessing** preventive care services."

REVISION X

NOW, THEREFORE, 9. GRIEVANCE AND APPEAL PROCEDURES, as shown in the April 1, 2008 contract shall be revised and amended and shall now read as follows:

"9 GRIEVANCE AND APPEAL PROCEDURES

The Contractor shall establish and maintain a procedure for the receipt and prompt internal resolution of all grievances and appeals in accordance with S.C. Code Ann. §38-33-110 (Supp. 2002) as amended and 42 C.F.R. Section 438.400, et seq. The Contractor's grievance and appeals procedures and any changes thereto must be approved in writing by SCDHHS prior to their implementation and must include at a minimum the requirements set forth herein. The Contractor shall refer all Medicaid MCO program members who are dissatisfied with the Contractor or its subcontractor in any respect to the Contractor's designee authorized to require corrective action. In all cases, where the member has a grievance

about treatment by the Contractor, or its subcontractor, the member must exhaust the Contractor's internal grievance/appeal procedures prior to accessing the State's Fair Hearing process.

9.1 Definitions

9.1.1 Action means:

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

9.1.1.2 The reduction, suspension, or termination of a previously authorized service;

9.1.1.3 The denial, in whole or in part, of payment for a service;

9.1.1.4 The failure to provide services in a timely manner, as defined by the State;

9.1.1.5 The failure of the Contractor to act within the timeframes provided in Section 9.7.1; or

9.1.1.6 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 C.F.R. Section 438.52(b)(2)(ii), to obtain services outside the network.

9.1.2 Appeal means a request for review of an action, as ``action'' is defined in this section.

9.1.3 Grievance means an expression of dissatisfaction about any matter other than an action, as ``action'' is defined in this section. 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.)

9.2 General Requirements

9.2.1 The grievance system. The Contractor must have a system in place for members that includes a grievance process, an appeal process, and access to the State's Fair Hearing system, once the Contractor's appeal process has been exhausted.

9.2.2 Filing **R**~~r~~equirements

9.2.2.1 Authority to file.

9.2.2.1.1 A 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.

9.2.2.1.2 A provider, acting on behalf of the member and with the member's written consent, may file an appeal. A provider may file a grievance or request a State Fair Hearing on behalf of an member, if the State permits the provider to act as the member's authorized representative in doing so.

9.2.2.2 Timing. The member must be allowed thirty (30) calendar days from the date on the Contractor's notice of action. Within that timeframe:

9.2.2.2.1 The member may file an appeal or the provider may file an appeal on behalf of the member.

9.2.3 Procedures.

9.2.3.1 The member may file a grievance either orally or in writing with the Contractor.

9.2.3.2 The member or the provider may file an appeal either orally or in writing, and unless he or she requests expedited resolution, must follow an oral filing with a written, signed, appeal.

9.3 Notice of Grievance and Appeal Procedures

The Contractor shall ensure that all Medicaid MCO program members are informed of the State's Fair Hearing process and of the Contractor's grievance and appeal procedures. The Contractor shall provide to each member a member handbook that shall include descriptions of the Contractor's grievance and appeal procedures. Forms on which members may file grievances, appeals, concerns or recommendations to the Contractor shall be available through the Contractor, and must be provided upon request of the member.

9.4 Grievance/Appeal Records and Reports

A copy of an oral grievances log and records of disposition of written appeals shall be retained for three (3) years and in accordance with the provisions of the S.C. Code Ann. § 38-33-110 (2)(a) (Supp. 2002) as amended. If any litigation, claim negotiation, audit, or other action involving the documents or records has been started before the expiration of the three (3) year period, the records shall be retained until completion of the action and

resolution of issues which arise from it or until the end of the regular five-year period, whichever is later.

The Contractor shall provide to SCDHHS on a quarterly basis a written report of the grievances/appeals, to include: member's name and Medicaid number, summary of grievances and appeals; date of filing; current status; resolutions and resulting corrective action. The Contractor will be responsible for promptly forwarding any adverse decisions to SCDHHS for further review/action upon request by SCDHHS or the Medicaid MCO Program member. The SCDHHS may submit recommendations to the Contractor regarding the merits or suggested resolution of any grievance/appeal. See MCO Policy and Procedure Guide.

9.5 Handling of Grievances and Appeals

The grievance and appeal procedures shall be governed by the following requirements:

9.5.1 General requirements.

In handling grievances and appeals, the Contractor must meet the following requirements:

9.5.1.1 Give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

9.5.1.2 Acknowledge receipt of each grievance and appeal.

9.5.1.3 Ensure that the individuals who make decisions on grievances and appeals are individuals:

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

9.5.1.3.2 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 member's condition or disease.

9.5.1.3.2.1 An appeal of a denial that is based on lack of medical necessity.

9.5.1.3.2.2 A grievance regarding denial of expedited resolution of an appeal.

9.5.1.3.2.3 A grievance or appeal that involves clinical issues.

9.5.2 Special ~~r~~**R**equirements for ~~a~~**A**ppeals.

The process for appeals must:

9.5.2.1 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 member or the provider requests expedited resolution.

9.5.2.2 Provide the 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 member of the limited time available for this in the case of expedited resolution.)

9.5.2.3 Provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.

9.5.2.4 Include, as parties to the appeal:

9.5.2.4.1 The member and his or her representative; or

9.5.2.4.2 The legal representative of a deceased member's estate.

9.5.3 The Contractor's staff shall be educated concerning the importance of the grievance and appeal procedures and the rights of the member and providers;

9.5.4 The appropriate individual or body within the Contractor's plan having decision making authority as part of the grievance/appeal procedure shall be identified;

9.6 Notice of Action

9.6.1 Language and format requirements

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

9.6.2 Content of ~~n~~**N**otice

The notice must explain the following:

9.6.2.1 The action the Contractor or its subcontractor has taken or intends to take.

9.6.2.2 The reasons for the action.

9.6.2.3 The member's or the provider's right to file an appeal with the Contractor.

9.6.2.4 The member's right to request a State Fair Hearing, after the Contractor's appeal process has been exhausted.

9.6.2.5 The procedures for exercising the rights specified in this section.

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

9.6.2.7 The 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 member may be required to pay the costs of these services.

9.6.3 Timing of ~~n~~**N**otice

The Contractor must mail the notice within the following timeframes:

9.6.3.1 For termination, suspension, or reduction of previously authorized Medicaid-covered services, at least 10 days before the date of action, except as permitted under 42 C.F.R. Sections 431.213 and 431.214.

9.6.3.2 For denial of payment, at the time of any action affecting the claim.

9.6.3.3 For standard service authorization decisions that deny or limit services, as expeditiously as the 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:

9.6.3.3.1 The member, or the provider, requests extension; or

9.6.3.3.2 The Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.

9.6.3.4 If the Contractor extends the timeframe in accordance with Section 9.6.3.3.1 or 9.6.3.3.2, it must:

9.6.3.4.1 Give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision; and

9.6.3.4.2 Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.

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

9.6.3.6 For expedited service authorization decisions where a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the 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 member's health condition requires and no later than three (3) working days after receipt of the request for service.

9.6.3.6.1 The Contractor may extend the three (3) working days time period by up to fourteen (14) calendar days if the member requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest.

9.6.3.7 The SCDHHS shall conduct random reviews to ensure that members are receiving such notices in a timely manner.

9.7 Resolution and Notification

Basic rule. The Contractor must dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the

member's health condition requires, within the timeframes established in **Section 9.7.1** below.

9.7.1 Specific timeframes:

9.7.1.1 Standard ~~d~~**D**isposition of ~~g~~**G**rievances

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

9.7.1.2 Standard ~~r~~**R**esolution of ~~a~~**A**ppeals

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 Section 9.7.2 of this section.

9.7.1.3 Expedited ~~r~~**R**esolution of ~~a~~**A**ppeals

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

9.7.2 Extension of timeframes

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

9.7.2.1.1 The member requests the extension; or

9.7.2.1.2 The Contractor shows (to the satisfaction of the State, upon its request) that there is need for additional information and how the delay is in the member's interest.

9.7.2.2 Requirements ~~f~~**F**ollowing ~~e~~**E**xtension

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

9.7.3 Format of ~~n~~**N**otice

9.7.3.1 Grievances. The State must establish the method the Contractor will use to notify an member of the disposition of a grievance.

9.7.3.2 Appeals.

9.7.3.2.1 For all appeals, the Contractor must provide written notice of disposition.

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

9.7.4 Content of ~~n~~**N**otice of ~~a~~**A**ppeal ~~r~~**R**esolution

The written notice of the resolution must include the following:

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

9.7.4.2 For appeals not resolved wholly in favor of the members:

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

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

9.7.4.2.3 That the member may be held liable for the cost of those benefits if the hearing decision upholds the Contractor's action.

9.7.5 Requirements for State Fair Hearings

9.7.5.1 Availability. If the member has exhausted the Contractor level appeal procedures, the member may request a State Fair Hearing within thirty (30) days from the date of the Contractor's notice of resolution.

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

9.8 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 member) or the provider indicates (in making the request on the member's behalf or

supporting the 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.

9.8.1 Punitive Action

The Contractor must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a~~n~~ member's appeal.

9.8.2 Action Following Denial of a Request for Expedited Resolution

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

9.8.2.1 Transfer the appeal to the timeframe for standard resolution in accordance with **Section 9.7.1.2;**

9.8.2.2 Make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

9.8.3 Failure to Make a Timely Decision

Appeals shall be resolved no later than above stated time frames and all parties shall be informed of the Contractor's decision. If a determination is not made by the above time frames, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made.

9.9 Continuation of Benefits while the Contractor Appeals and the State Fair Hearing is Pending

9.9.1 Terminology. As used in this section, "timely" filing means filing on or before the later of the following:

9.9.1.1 Within ten (10) days of the Contractor mailing the notice of action.

9.9.1.2 The intended effective date of the Contractor's proposed action.

9.9.2 Continuation of Benefits

The Contractor must continue the member's benefits if:

9.9.2.1 The member or the provider files the appeal timely;

9.9.2.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

9.9.2.3 The services were ordered by an authorized provider;

9.9.2.4 The original period covered by the original authorization has not expired; and

9.9.2.5 The member requests extension of benefits.

9.9.3 Duration of ~~c~~**C**ontinued or ~~r~~**R**einstated ~~b~~**B**enefits

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

9.9.3.1 The member withdraws the appeal.

9.9.3.2 Ten (10) days pass after the Contractor mails the notice, providing the resolution of the appeal against the member, unless the member, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State Fair Hearing decision is reached.

9.9.3.3 A State Fair Hearing Officer issues a hearing decision adverse to the member.

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

9.9.4 Member ~~r~~**R**esponsibility for ~~s~~**S**ervices ~~f~~**F**urnished ~~w~~**W**hile the ~~a~~**A**ppeal is ~~p~~**P**ending

If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 C.F.R. Section 431.230(b).

9.10 <u>Information About the Grievance System to Providers and Subcontractors</u>

The Contractor must provide the information specified at 42 C.F.R. Section 438.10(g)(1) about the grievance system to all providers and subcontractors at the time they enter into a contract.

9.11 <u>Recordkeeping and Reporting Requirements</u>

Reports of grievances and resolutions shall be submitted to SCDHHS as specified in §§8.4, 9 and 10.8 of this Contract. The

Contractor shall not modify the grievance procedure without the prior written approval of SCDHHS.

9.12 Effectuation of Reversed Appeal Resolutions

9.12.1 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 member's health condition requires.

9.12.2 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 member received the disputed services while the appeal was pending, the Contractor or the State must pay for those services, in accordance with State policy and regulations."

REVISION XI

NOW, THEREFORE, 10. REPORTING REQUIREMENTS, as shown in the April 1, 2008 contract shall be revised and amended and shall now read as follows:

"10. REPORTING REQUIREMENTS

The Contractor is responsible for complying with all the reporting requirements established by SCDHHS. The Contractor must demonstrate the capability to connect using TCP/IP protocol on a specific port using ConnectDirect software. Connectivity must be verified by SCDHHS in writing and shall provide SCDHHS a sample of all hard copy reports prior to Contract execution for prior approval. The requirements for electronic files can be found in MCO Policy and Procedure Guide. The Contractor shall provide to SCDHHS and any of its designees copies of agreed upon reports generated by the Contractor concerning Medicaid MCO program members and any additional reports as requested in regard to performance under this Contract. SCDHHS will provide the Contractor with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. All reporting periods are specified in the MCO Policy and Procedure Guide. All reports shall be submitted in accordance with the schedule outlined in the ~~Liquidated Damages~~ § 13.3 of this Contract. In the event that there are no instances to report, the Contractor shall submit null reports. The Minimum Data Elements and required formats for these reports are outlined in MCO Policy and Procedure Guide. Additional reports may be required in the MCO Policy and Procedure Guide. The Contractor shall certify all submitted data, documents and reports. The certification must attest, based on best knowledge, information, and belief (1) to the accuracy,

completeness and truthfulness of the data; and (2) to the accuracy, completeness and truthfulness of all documents and reports required by SCDHHS. The data shall be certified 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. Certification shall be submitted concurrently with the certified data.

10.1 Contractor's Network Providers and Subcontractors

The Contractor shall furnish to SCDHHS or its designee a monthly report of all network providers and subcontractors enrolled in the Contractor's plan, including but not limited to, primary care providers, 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 program members under this Contract. The Contractor shall also furnish to SCDHHS or its designee adequate copies of the PCP listing as requested by SCDHHS. SCDHHS will provide the Contractor with Medicaid provider identification numbers. It shall be the Contractor's responsibility to assure confidentiality of the Medicaid Providers' identification number and indemnity of SCDHHS in accordance with § 13.26 of this Contract. The SCDHHS is to be provided advance copies of all updates not less than ten (10) working days in advance of distribution. Any provider no longer taking new patients must be clearly identified. Any age restrictions for a provider must be clearly identified. 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 Medicaid program, the Contractor shall furnish to SCDHHS, a monthly file utilizing the ~~file requirements as specified in the **MCO Policy and Procedure Guide.** The~~ Minimum Data Elements and required format ~~are~~ identified in the MCO Policy and Procedure Guide.

~~10.2 Medicaid MCO Program Member Insured's Policy Number~~

~~The Contractor shall be required to furnish SCDHHS the unique policy number assigned to the Medicaid MCO Program member by the Contractor monthly utilizing the file requirements as specified in the **MCO Policy and Procedure Guide.** The Contractor's Minimum Data Elements and required format are identified in the **MCO Policy and Procedure Guide.**~~

10.2 FQHC/RHC Encounter Reporting

The Contractor shall submit on a quarterly basis by date of service, a report of encounter/claim data of all contracting FQHCs and RHCs for State Plan required reconciliation purposes. Please see the MCO Policy and Procedure Guide for FQHC/RHC Encounter Reporting for reporting

specifications. The encounter data shall be submitted no later than sixty (60) days following the quarter's end.

10.3 Reporting of Other Insurance

All persons enrolled in any other health plan, shall be reported monthly in a standardized format as specified in the MCO Policy and Procedure Guide. ~~The Minimum Data Elements and required format are identified in the **MCO Policy and Procedure Guide.**~~

10.4 Individual Encounter Reporting

The Contractor must submit encounter/claim data to SCDHHS 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 ~~Section~~ **§**13.3 utilizing the file requirements as specified in the MCO Policy and Procedure 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 SCDHHS. Contractor agrees, if required, to submit encounter data utilizing the HIPAA compliant transaction format. The Minimum Data Elements and required format are identified in the MCO Policy and Procedure Guide.

For encounter data submissions, the Contractor shall submit 100% of their encounter data at least monthly due no later than the twenty-fifth (25th) business day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00). Encounter data should be submitted in the required format established by SCDHHS in the MCO Policy and Procedure Guide. Nothing in this Contract shall prohibit the Contractor from submitting encounter data more frequently than monthly. Each encounter data submission shall be accompanied by a statement of certification of the number of paid claims/encounters identified by date of service. SCDHHS shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. All submitted data must be 100% correct no later than 90 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 90 day limit. 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 member.

Encounter data received from the Contractor will be enhanced and edited by standards established by SCDHHS. In addition to this requirement, the Contractor shall provide a monthly summary which identifies the number of encounters submitted and identified by the date of service. This summary is due to the Department of Managed Care five (5) business days after the end of the month in a format specified in the MCO Policy and Procedure Guide. SCDHHS will

furnish an enhanced version of the encounter file (MCO Policy and Procedure Guide) to the Contractor within a timeframe to be determined by SCDHHS. The enhanced version encounter record will contain additional data elements obtained from the Medicaid Management Information System (MMIS) and will contain specific encounter/ edit information. The Contractor will receive an edit report (MCO Policy and Procedure Guide) for each encounter submission.

10.5 Abortion Reporting

The Contractor shall submit on a monthly basis, a report of all therapeutic abortions performed. 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.

10.6 Grievance/Appeal Log Summary Reporting

The Contractor shall log grievance/appeal information regarding all active and resolved grievances/appeals on a monthly basis and submit **the log to SCDHHS** quarterly. The Minimum Data Elements and required format are identified in the MCO Policy and Procedure Guide.

10.7 Institutional Long Term Care/Nursing Home Reporting

The Contractor shall notify SCDHHS or its designee when a Medicaid MCO program member requires institutionalization in a long-term care facility/nursing home and again at the time the 30th day of placement is completed.

10.8 Disenrollment Reporting

The Contractor shall submit to SCDHHS disenrollment requests for approval in accordance with §§ 6.5 & 6.6. The Contractor shall immediately notify SCDHHS when it obtains knowledge of any Medicaid MCO program member whose enrollment should be terminated. See MCO Policy and Procedure Guide for a sample form. SCDHHS will furnish forms to the Contractor upon request.

~~10.9 Newborn Notice~~

~~The Contractor shall notify SCDHHS or its designee of any newborn, determined by the Contractor to be the infant of a plan member. The mother's name and Medicaid number must be accurate to ensure payment of the maternity kicker payment. Form 1716 ME shall be utilized. See **MCO Policy and Procedure Guide** of this Contract.~~

10.~~10~~**9** Quality Assessment and Performance Improvement

The Contractor will submit reports of Quality Assessment and Performance Improvement (QAPI) activities, including **a**~~,~~ QA~~PI~~ Work ~~P~~**p**lan, Plan of Correction (POC), Utilization Management (UM) activities and Workplan, **Program Integrity Workplan** and Quality Measures documentation in accordance with the periodicity contained in § 11 and MCO Policy and Procedure Guide of this Contract.

The Contractor shall collect information to report all HEDIS measures designated by SCDHHS in this Contract and the MCO Policy and Procedure Guide. The Contractor is to begin collecting HEDIS measures in calendar years 2009-2010 and submit them to SCDHHS. However, the Contractor is not required to submit audited HEDIS results to SCDHHS 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.~~11~~**10** Member Satisfaction Survey

The Contractor will conduct an annual Member Satisfaction Survey, utilizing **the Consumer Assessment of Healthcare Providers and Systems (**CAHPS**) survey criteria** and submit the survey results and a copy of the instrument used to SCDHHS. **SCDHHS will coordinate with the Contractor to determine the schedule for conducting the survey and submitting the results to SCDHHS.** Should the Contractor utilize an outside vendor, said vendor ~~will~~**must** have national accreditation and approval from SCDHHS, prior to conducting the survey.

10.11 Pay For Reporting

SCDHHS recognizes the importance of monitoring Contractor performance throughout the calendar year, and the Contractor will be required to submit quarterly Capitation Rate Calculation Sheet (CRCS) reports to SCDHHS in a timely, complete and accurate manner. The data elements and other requirements for the report format are set forth in the MCO Policy and Procedure Guide. CRCS reports are due within one hundred five (105) days of the end of each calendar quarter. Each quarterly report must include year-to-date information.

10.11.1 Capitation Rate Calculation Sheet (CRCS) Requirements

The Contractor must ensure that the CRCS report:

10.11.1.1 Is submitted in a timely, complete and accurate manner; and

10.11.1.2 Can be verified to a degree of at least 95% completeness for all claims (i.e., an incompleteness rate of no more than 5%). SCDHHS will use the Contractor's encounter data, or other method of data completion verification deemed reasonable by SCDHHS, to verify the completeness of the CRCS report in comparison to the Contractor's encounter claims. SCDHHS reserves the right to change the method of data completion verification upon reasonable advance notice to the Contractor.

In the event the Contractor's CRCS report fails to meet the standards described above, SCDHHS will assess a penalty of one quarter percent (0.25%) of the capitation payment to the Contractor for each month of the reporting quarter. These penalty funds will be withheld from future capitation payments or other payable accounts to the Contractor.

10.11.2 <u>Disposition of Penalty Funds</u>

SCDHHS will retain all penalty funds and may make such funds (including funds forfeited by other MCO contractors) available to the Contractor to fund all or a portion of quality improvement initiatives proposed by Contractors.

~~10.12 <u>Medicaid Enrollment Capacity by County Report</u>~~

~~Monthly and upon request, the Contractor shall submit a Medicaid Enrollment Capacity by county report. The Minimum Data Elements' and required format are identified in the **MCO Policy and Procedure Guide.**~~

10.~~13~~**12** <u>Additional Reports</u>

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

10.~~14~~**13** Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of Medicaid prepaid health plans (42 CFR 455.100-455.104 (2006, as amended)). Form CMS 1513, Ownership and Control Interest Statement, is to be submitted to SCDHHS with this Contract; then resubmitted prior to implementation for 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 SCDHHS within thirty (30) calendar days prior to the effective date of the change.

10.~~15~~**14** Information Related to Business Transactions

The Contractor agrees to furnish to SCDHHS or to HHS information related to significant business transactions as set forth in 42 CFR 455.105 (2006, as amended). Failure to comply with this requirement may result in termination of this Contract.

The Contractor also agrees to submit, within 35 days of a request made by SCDHHS, 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 fiscal year that exceed the $25,000 or 5% of the Contractor's total operating expenses.

10.~~16~~**15** Information on Persons Convicted of Crimes

The Contractor agrees to furnish SCDHHS or HHS information related to 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 (2006, as amended). Failure to comply with this requirement may lead to termination of this Contract.

10.~~17~~**16** Errors

The Contractor agrees to prepare complete and accurate reports for submission to SCDHHS as defined in § 13.3 and in the format described in **the MCO Policy and Procedure Guide**~~13.42~~. If after preparation and submission, a Contractor error is discovered either by the Contractor or SCDHHS, the Contractor will have to 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 - 15 calendar days from the date of discovery by the Contractor or date of written notification by DHHS (whichever is earlier);

Failure of the Contractor 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.~~18~~**17** Coding Requirements

The Contractor must use the following coding sources when reporting data to SCDHHS. The Contractor and its subcontractor must utilize the coding sources as defined in this section. Neither the Contractor nor its subcontractors may redefine or substitute these required codes.

(a) Diagnosis codes obtained from the International Classification of Disease Clinical Modification (ICD-9-CM).

(b) Procedural codes obtained from the Physicians' Current Procedural Terminology (CPT) Code book; CMS Common Procedure Coding System (HCPCS) Level II National Code book; and local assigned codes for which there is no national code.

(c) UB-**04**~~92~~ Codes obtained from the South Carolina Uniform Billing Manual."

REVISION XII

NOW, THEREFORE, 11. QUALITY ASSESSMENT, MONITORING AND REPORTING, as shown in the April 1, 2008 contract shall be revised and amended and shall now read as follows:

“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 42CFR 456 and stated within the MCO Policy and Procedure Guide. ~~The Contractor will have an ongoing Continuous Quality Improvement (CQI) program for the services furnished to its members that meets the requirements of 42CFR 438.200. The Contractors Medical Director will be responsible for managing the CQI program~~. The Contractor will submit, annually by December 15, its ~~QAPI~~ **Quality Assessment** Workplan, UM Workplan and **Program** Integrity Plan to SCDHHS for review and approval. Any subsequent changes or revisions must be submitted to SCDHHS 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 will agree to **an** External Quality Review, review of ~~QAPI / CQI / UM~~ **Quality Assessment Committee** meeting minutes and annual medical audits to ensure that it provides quality and accessible health care to Medicaid MCO program members, in accordance with standards contained in the MCO Policy and Procedure Guide and under the terms of this Contract. Such audits shall allow SCDHHS or its duly authorized representative to review individual medical records, 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 sole discretion and approval of SCDHHS. 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. SCDHHS must prior approve the POC and will monitor the Contractor's progress in correcting the deficiencies. See MCO Policy and Procedure Guide.

~~The Contractor must attain accreditation by a nationally recognized organization such as the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC) within a reasonable time period, not to exceed four years from the initial county network approval date. SCDHHS will consider other nationally recognized organizations, but prior approval from the SCDHHS QAPI department must be obtained prior to survey application.~~

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. Accreditation must be completed by December 31, 2012 and must be maintained during the life of this Contract. The Contractor must provide SCDHHS' Division of Managed Care with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements. Failure to obtain NCQA accreditation by December 31, 2012 and maintain the accreditation thereafter shall be considered a breach of this Contract and shall result in termination of this Contract. Achievement of provisional accreditation status shall require a plan of correction within thirty (30) calendar days of receipt of the Final Report from NCQA and may result in termination of this Contract.

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. HEDIS measures for calendar years 2009-2010 must be submitted to SCDHHS in the manner specified in the MCO Policy and Procedure Guide. It is encouraged that the 2009-2010 measures be submitted in accordance with the NCQA-specified standards and auditing and submission process. Beginning with calendar year 2011 data, HEDIS measures must be submitted in accordance with the NCQA-specified standards and auditing and submission process. SCDHHS may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

11.1.2 Pay for Performance

As set forth in Appendix D, SCDHHS will implement a Pay for Performance program in 2011. Any potential payments to the Contractor will occur in 2012 based on 2011 HEDIS data. Failure to report HEDIS measures to SCDHHS will result in liquidated damages as set forth in §13.3 of this Contract.

11.2 Inspection, Evaluation and Audit of Records

At any time during normal business hours, HHS, the State Auditor's Office, the Office of the Attorney General, General Accounting Office (GAO), Comptroller General, SCDHHS, 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 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, SCDHHS, 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 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 provisions 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. This provision is applicable to any subcontractor and must be included in all subcontracts. SCDHHS and/or any designee will also have the right to:

11.2.1 Inspect and evaluate the qualifications and certification or licensure of Contractor's subcontractors;

11.2.2 Evaluate, through inspection of Contractor and its subcontractor's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to members;

11.2.3 Evaluate the Contractor's performance for the purpose of determining compliance with the requirements of the Contract;

11.2.4 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; and

11.2.5 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.

11.2.~~5~~**6The** Contractor agrees to provide, upon request, all necessary assistance in the conduct of the evaluations, inspections, and audits.

11.2.~~6~~**7** ~~The~~ SCDHHS shall monitor enrollment and termination practices and ensure proper implementation of the Contractor's grievance procedures, in compliance with 42 CFR 438.226-438.228 (2006, as amended). SCDHHS and its designee shall have access to all information related to complaints and grievances filed by Medicaid MCO Program members.

The Contractor 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, and SCDHHS policy.

11.3 Changes Resulting from Monitoring and Audit

The Contractor will be responsible for assuring corrective actions are taken when a Contractor's or subcontractor's quality of care is inadequate. SCDHHS reserves the right to suspend enrollment in the plan if it is determined that quality of care is inadequate. See MCO Policy and Procedure Guide.

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

11.4 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 program member enrolled under this Contract. Each 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 SCDHHS representatives or its designee shall have immediate and complete access to all records pertaining to the health care services provided to Medicaid MCO program members. Medical record requirements are further defined in the **MCO Policy and Procedure Guide**.

11.5 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 members relating to the delivery of care or service under this Contract, and as further required by SCDHHS, for a period of five (5) years from the expiration date of the Contract, including any Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five (5) year period, whichever is later. If 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.

~~**This provision is applicable to any subcontractor and must be included in all subcontracts."**~~

REVISION XIII

NOW, THEREFORE, 12. SCDHHS RESPONSIBILITIES, as shown in the April 1, 2008 contract shall be revised and amended and shall now read as follows:

12 SCDHHS RESPONSIBILITIES

12.1 SCDHHS Contract Management

The SCDHHS will be responsible for the administrative oversight of the Medicaid MCO Program. As appropriate, SCDHHS will provide clarification of Medicaid MCO Program and Medicaid policy,

regulations and procedures. The SCDHHS will be responsible for management of this Contract. All Medicaid policy decision making or Contract interpretation will be made solely by SCDHHS. The management of this Contract will be conducted in the best interests of SCDHHS and the Medicaid MCO Program members.

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

12.2 Payment of Capitated Rate

The Contractor shall be paid in accordance with the capitated rates specified in Appendix B, Capitation Rate(s) and Rate Methodology. These rates will be reviewed and adjusted periodically. These rates shall not exceed the limits set forth in 42 CFR 438.6 (c).(2005, as amended).

12.3 Required Submissions

Prior to execution of this contract, the MCO shall submit to SCDHHS Required Submissions documents, as described in the MCO Policy and Procedure Guide SCDHHS 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, Contractor shall submit a complete copy of all Required Submission documents in a format specified in ~~Section 13.42~~**the MCO Policy and Procedure Guide** Thereafter, on January 15th of each year, the Contractor shall submit, in the aforementioned format, only approved additions, changes and modification which have been submitted and approved during this year.

12.4 Immunization Data

Plans are encouraged to work with DHEC to match immunization data with plan member records.

12.4**5** Notification of Medicaid MCO Program Policy and Procedures

SCDHHS will provide the Contractor with updates to appendices, information and interpretation of all pertinent federal and state Medicaid regulations, Medicaid MCO Program policies, procedures and guidelines affecting the provision of services under this Contract. The Contractor will submit written requests to SCDHHS for additional clarification, interpretation or other information in a grid format specified by SCDHHS. 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~~**6** Provider Participation

SCDHHS will notify the Contractor in writing, of providers who have been suspended or terminated from participation in the Medicaid/Medicare Program. Monthly, SCDHHS will notify the Contractor of current Medicaid providers to assist the Contractor in care coordination and encounter data reporting.

12.~~6~~**7** Quality Assessment and Monitoring Activities

SCDHHS is responsible for monitoring the Contractor's performance to assure the Contractor is in compliance with the Contract provisions and the MCO Policy and Procedure Guide. . SCDHHS 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.

SCDHHS or its designee, will at least annually monitor the operation of the Contractor for compliance with the provisions of this Contract, the MCO Policy and Procedure Guide, and applicable federal and state laws and regulations. **Inspection shall include 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 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 contract monitoring and audits. However, once SCDHHS finalizes the results of monitoring and/or audit report, the Contractor must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in liquidated damages, sanctions and/or enrollment restrictions.

12.~~6~~**7**.1 ~~Quality Measures and HEDIS~~ **Fee-for-Service Reporting to MCOs**

~~The Contractor is required to conduct quality of care outcome studies which include quality measures for HEDIS, prenatal care, newborns, childhood immunizations, asthma, ER utilization and EPSDT services. The **MCO Policy and Procedure Guide,** Quality Measures, lists the SCDHHS quality measures. SCDHHS may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.~~**The SCDHHS will be responsible for providing MCOs with a recent retrospective fee-for-service history on all current members, if available. This history will go back a maximum of twelve months from the month of initial plan membership.**

12.~~6~~**7**.2 Request for Plan of Correction

The SCDHHS will monitor the Contractor's quality 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~~**7**.3 External Quality Review

The SCDHHS will perform periodic medical audits through contractual arrangements to determine if the Contractor furnished quality and accessible health care to Medicaid MCO program members in compliance with 42 CFR 438.358 (2006, as amended). SCDHHS ~~will~~**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 ~~and the Medicaid Managed Care External Review Services~~ lists SCDHHS external quality assessment evaluation requirements.

12.~~7~~**8** Marketing

SCDHHS, and/or its designee shall have the right to approve, disapprove or require modification of all marketing plans, materials, and activities, enrollment and member handbook materials developed by the Contractor under this Contract and prior to implementation/distribution by the Contractor. See Section 7 of this Contract and the MCO Policy and Procedure Guide for guidance.

12.~~8~~**9** Grievance/Appeals

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

12.~~9~~**10** Training

SCDHHS will conduct provider training and workshops on Medicaid MCO Program policy and procedures as deemed appropriate for MCO Contractors.

12.~~10~~**11** Federal Fund Restrictions

SCDHHS will transmit to the Contractor, on a regular basis, information regarding individuals prohibited from receiving Federal funds who appear on the OIG electronic database."

REVISION XIV

NOW, THEREFORE, 13. TERMS AND CONDITIONS, as shown in the April 1, 2008 contract shall be revised and amended and shall now read as follows:

"13 TERMS AND CONDITIONS

The Contractor agrees to comply with all state and federal laws, regulations, and policies as they exist or as amended that are or may be applicable to this Contract, including those not specifically mentioned in this section. 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 policy. Such amendment of the Contract will be effective on the effective date of the statutes, regulations, or policy statement necessitating it, 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 SCDHHS to 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** SCDHHS.

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 and 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 25**A** 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) and regulations issued pursuant

thereto, 45 CFR part 80; In accordance with Title VI of the Civil Rights Act of 1964 (42U.S.C. 2000d et seq.) and its implementing regulation at 45 C.F.R. Part 80, the Provider 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 agreement.

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.**E.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 Americans with Disabilities Act, as amended, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto~~, 28 CFR Parts 35, 36~~;

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 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, (2006, as amended); ~~and~~

~~13.1.13 Debarment/Suspension, as contained in 45 CFR Part 76 (2006, as amended).~~

13.1.~~14~~**13** Title IX of the Education Amendments of 1972 regarding education programs and activities;

13.2 Termination

This Contract shall be subject to the following termination provisions. SCDHHS 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 SCDHHS, give the Contractor a specific time period in which to correct the deficiencies, unless other provisions in this section demand otherwise, before an actual notice of termination is issued. If SCDHHS determines that the Contractor has satisfactorily implemented corrective action, a notice of termination will not be issued. If SCDHHS determines that the Contractor has not satisfactorily corrected the problem(s), a notice of termination will be issued. SCDHHS will provide Contractor with a written Notice of Intent to Terminate the contract between SCDHHS and the Contractor. The Notice of Intent to Terminate will include the date, time and location of a fair hearing before the SCDHHS 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. SCDHHS or its designee will assume responsibility for informing all affected members of the reasons for their termination from the Contractor. **Members shall be allowed to disenroll immediately without cause.**

13.2.1 Termination Under Mutual Agreement

Under mutual agreement, SCDHHS and the Contractor may terminate this Contract for any reason if it is in the best interest of SCDHHS 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.

13.2.2 Termination by SCDHHS for Breach

In the event that SCDHHS 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, SCDHHS may terminate this Contract upon thirty (30) calendar days 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 SCDHHS 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 SCDHHS.

SCDHHS 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 of Medicaid MCO Program members enrolled in the Contractor's plan.

The Contractor will be paid for any outstanding monies due less any assessed damages. 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. The rights and remedies of the SCDHHS 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 contract expiration date, SCDHHS may terminate the Contract without penalty. This notification will be made in writing. Availability of funds shall be determined solely by SCDHHS.

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 for cause. If the SCDOI and SCDHHS determine the Contractor has become financially unstable and/or the Contractor's license is revoked, SCDHHS will immediately terminate this Contract upon written notice to the Contractor effective the close of business on the date specified.

13.2.5 Termination for Convenience

SCDHHS may terminate this Contract for convenience and without cause upon thirty (30) calendar days written notice. Said termination shall not be a breach of contract by SCDHHS and SCDHHS shall not be responsible to the Contractor or any other party for any costs, expenses, or damages occasioned by said termination, i.e., without penalty.

13.2.6 Termination by the Contractor

The Contractor shall give SCDHHS written notice of intent to terminate this Contract ninety (90) calendar days prior to the date of receipt of written notice by SCDHHS. Such written

notice may be either hand-delivered to SCDHHS or may be mailed by certified mail, return receipt requested. The ninety (90) calendar days written notice shall specify the last date of operation, such date being at least ninety (90) calendar days termination from documented receipt of the notice of termination. The Contractor shall comply with all terms and conditions stipulated in this Contract during the close out period.

13.2.7 Termination for Loss of Licensure or Certification

In the event that the Contractor loses its license to operate or practice from the SCDOI or the appropriate licensing agency, 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, as applicable, this Contract shall terminate as of the date of such decertification.

13.2.8 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.

13.2.9 Termination for Cause

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 Sections 1128 (a) and 1128 (b)(1), (2), or (3) of the Social Security Act, in accordance with ~~§1002.203~~ of 42 CFR **§1002.203;**~~.~~
   b. Has had civil monetary penalties or assessment imposed under Section 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 ~~of the contractor~~**,** if it is organized as a partnership~~;~~**, or** is an agent or ~~is~~ a managing employee.

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

13.2.10 Termination Procedures

The party initiating the termination shall render written notice of termination to the other party by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall specify the provision of this Contract giving the right to terminate; the circumstances giving rise to termination; and the date on which such termination shall become effective. When applicable, SCDHHS shall proceed with termination in accordance with § 13.2 and § 13.5.11 of this Contract.

~~Upon receipt of notice of termination, and s~~**S**ubject to the provisions stated herein, ~~on the date and to the extent specified in the notice of termination~~**once the notice of termination has been submitted to SCDHHS**, the Contractor shall:

13.2.10.1 ~~Stop work~~**Continue to provide services** under the Contract, ~~but not before~~ **until** the termination **effective** date;

13.2.10.2 **Immediately** ~~T~~**t**erminate all marketing procedures and subcontracts related to marketing;

13.2.10.3 **Within ten (10) days of the Contractor's written notification to SCDHHS of its intent to terminate its contract, submit a termination plan to SCDHHS for review and approval. The Contractor shall make revisions to the plan as necessary or as required by SCDHHS and will resubmit the plan to SCDHHS for approval after each revision. Failure to submit a termination plan within ten (10) days of written notification to SCDHHS of termination or to timely resubmit the plan after revisions may, in SCDHHS' 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 25%**

of the Contractor's monthly capitation payment. These funds will be withheld until SCDHHS receives the termination plan.

13.2.10.4 Agree to maintain claims processing functions as necessary for a minimum of nine (9) months (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims.

13.2.10.5 Remain liable and retain responsibility for all claims with dates of service through the day of termination.

13.2.10.6 Be financially responsible through their date of discharge for patients who are hospitalized prior to the termination date.

13.2.10.7 Be financially responsible for services rendered prior to the termination date, for which payment is denied by the MCO and subsequently approved upon appeal by the provider.

13.2.10.8 Be financially responsible for member appeals of adverse decisions rendered by the MCO concerning treatment requested prior to the termination date which are subsequently determined in the member's favor after an appeal proceeding or a State Fair Hearing.

13.2.10.9 Assist SCDHHS with grievances and appeals for dates of service prior to the termination date.

13.2.10.10 Arrange for the orderly transfer of patient care and patient records to those providers who will assume members' care. For those 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.

13.2.10.11 Notify all members in writing about the contract termination and the process by which members will continue to receive medical care at least 60 calendar days in advance of the effective date of termination. The Contractor will be responsible for all

expenses associated with member notification. SCDHHS must approve all member notification materials in advance of distribution. Such notice must include a description of alternatives available for obtaining services after Contract termination.

13.2.10.12 Notify all of its providers in writing about the contract termination at least 60 calendar days in advance of the effective date of termination. The Contractor will be responsible for all expenses associated with provider notification. SCDHHS must approve all provider notification materials in advance of distribution.

13.2.10.13 File all reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract.

13.2.10.14 Take all actions necessary to ensure the efficient and orderly transition of participants from coverage under this Contract to coverage under any new arrangement authorized by SCDHHS.

13.2.10.15 To ensure fulfillment of its obligations before and after termination, maintain the financial requirements, fidelity bonds and insurance set forth in this Contract until SCDHHS provides the Contractor written notice that all obligations of this Contract have been met.

13.2.10.16 Submit reports to SCDHHS every thirty (30) 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 SCDHHS describing how the Contractor has completed its obligations. SCDHHS shall, within twenty (20) calendar days of receipt of this report, advise in writing whether it agrees that the Contractor has

met its obligations. If SCDHHS does not agree, then the Contractor shall complete the necessary tasks and submit a revised final report. This process shall continue until SCDHHS approves the final report.

13.2.10.17 Take whatever other actions are required by SCDHHS to complete this transition.

13.2.10.18 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 and computer system and mailings by the enrollment broker to the Contractor's members regarding their choice period after the termination effective date.

13.2.10.~~3~~**19** **If applicable,** ~~A~~assign to SCDHHS in the manner and extent directed by SCDHHS all the rights, title and interest of the Contractor for the performance of the subcontracts to be determined as needed in which case SCDHHS shall have the right, in its discretion, to resolve or pay any of the claims arising out of the termination of such agreements and subcontracts. The Contractor shall supply all information necessary for the reimbursement of any outstanding Medicaid claims;

13.2.10.~~4~~**20** Complete the performance of such part of the Contract which shall have not been terminated under the notice of termination;

13.2.10.~~5~~**21** Take such action as may be necessary, or as SCDHHS may direct, for the protection of property related to this Contract which is in possession of the Contractor in which SCDHHS has or may acquire an interest;

13.2.10.~~6~~**22** In the event the Contract is terminated by SCDHHS, ~~the Contractor shall~~ continue to serve or arrange for provision of services to the members of the Contractor until the effective date of termination. During this transition period, SCDHHS shall continue to pay the applicable capitation rate(s). Members shall be given written notice of the State's intent to terminate the contract and shall be allowed to disenroll immediately without cause;

13.2.10.~~7~~**23** Provide all necessary assistance to SCDHHS in transitioning members out of the Contractor's 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 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 SCDHHS or any party acting on behalf of SCDHHS and shall be provided at no expense to SCDHHS or another Contractor acting on behalf of SCDHHS;

13.2.10.~~8~~**24** ~~The Contractor shall~~ ~~p~~**P**romptly supply all information necessary to SCDHHS or its designee for reimbursement of any outstanding claims at the time of termination;

~~13.2.10.9 Not receive its prepaid payment for any requests for payment submitted after the aforesaid Contract ends.~~ Any payments due under the terms of this Contract may be withheld until SCDHHS receives from the Contractor all written and properly executed documents ~~as required by the written instructions of SCDHHS~~**and the Contractor complies with all requests of SCDHHS.**

Once SCDHHS receives the notice of termination, SCDHHS shall:

1. **Stop auto-assignment of members to the terminating plan as of the date written notification of termination is received by SCDHHS.**
2. **Review, revise and approve the Contractor's termination plan and final report.**
3. **Review, revise and approve all correspondence to the Contractor's members and providers prior to distribution.**
4. **Cease all new member enrollments in the Contractor's plan at such time as determined by SCDHHS. This decision**

shall be at the sole discretion of SCDHHS.

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

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

13.2.11.1 Except as provided in Section 13.2.10.2 below, upon termination of this Contract, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.

13.2.11.2 In the event that Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon a mutual determination that return or destruction of Protected Health Information is infeasible, Business Associate 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 Business Associate maintains such Protected Health Information.

13.3 Liquidated Damages for Failure to Meet Contract Requirements

It is agreed by SCDHHS and the Contractor 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 SCDHHS and the actual damages which SCDHHS 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 SCDHHS liquidated damages in the fixed amount as 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 SCDHHS's failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting directly therefrom. **SCDHHS may impose liquidated damages upon the Contractor when it fails to timely and accurately submit any reports required under this Contract or the MCO Policy and Procedure Guide.**

For each day that a deliverable is late, incorrect, or deficient, the Contractor shall be liable to SCDHHS for liquidated damages in the amount of ~~One Hundred Dollars ($100.00)~~**One Thousand, Five Hundred Dollars ($1,500.00)** per ~~work~~**calendar** day, per file, report, encounter data submissions or other deliverable. With the exception of encounter data submissions, SCDHHS 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 SCDHHS.

~~For encounter data submissions, the Contractor shall submit 100% of their encounter data at least monthly due no later than twenty-five (25) business days after the end of the month) in the required format established by SCDHHS **(MCO Policy and Procedure Guide)** and in accordance with the deliverable schedule set forth in this section of the contract. Nothing in this Contract shall prohibit the Contractor from submitting encounter data more frequently than monthly. Each encounter data submission shall be accompanied by a statement of certification of the number of paid claims/encounters identified by date of service. SCDHHS shall conduct validation studies of encounter data, testing for timeliness, accuracy and completeness. All submitted data must be 100% correct no later than 90 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 90 day limit. 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 Enrollee.~~

~~Encounter data received from the Contractor will be enhanced and edited by standards established by SCDHHS. In addition to this requirement, the Contractor shall provide a monthly summary which identifies the number of encounters submitted and identified by the date of service. This summary is due to the Department of Managed Care five (5) business days after the end of the month in a format specified in the **MCO Policy and Procedure Guide.** SCDHHS will furnish an enhanced version of the encounter file~~

~~**(MCO Policy and Procedure Guide)** to the Contractor within a timeframe to be determined by SCDHHS. The enhanced version encounter record will contain additional data elements obtained from the Medicaid Management Information System (MMIS) and contain specific encounter/ edit information. The Contractor will receive an edit report **(MCO Policy and Procedure Guide)** for each encounter submission.~~

Liquidated damages for late reports or deliverables shall begin on the first day the report is late. Liquidated damages for incorrect reports or deficient deliverables shall begin on the sixteenth day after notice is provided from SCDHHS 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 following schedule:

Deliverables	**Date Agreed Upon**
Daily Reports	Within two (2) working days.
Weekly Reports	Wednesday of the following week.
Monthly Reports	15th of the following month with the exception of certain reports and due dates specified in the **MCO Policy and Procedure Guide**.
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) working days from the date of request unless otherwise specified by SCDHHS.
Encounter data – initial submission	**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**

LIQUIDATED DAMAGES

Employment of licensed personnel	~~$250.00~~**$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.~~8~~**7**	~~$500.00~~**$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 And CRCS report	**$1500.00 per calendar per file or report**
Encounter Data – failure to meet 100% accurate submission deadline as set forth in §10.4	**$1500.00 per calendar day**

It is further agreed by SCDHHS and the Contractor that any liquidated damages assessed by SCDHHS shall be due and payable to SCDHHS within thirty (30) calendar days after Contractor receipt of the notice of damages**.** ~~and i~~**I**f payment is not made by the due date, said liquidated damages shall be withheld from future capitation payments by SCDHHS without further notice. It is agreed by SCDHHS and the Contractor that the collection of liquidated damages by SCDHHS 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 SCDHHS will be returned to the Contractor.

Whenever liquidated damages for a single occurrence exceed $2,500.00, Contractor staff will meet with SCDHHS staff to discuss the causes for the occurrence and to negotiate a reasonable plan for corrective action of the occurrence. Once a corrective action plan is agreed upon by both parties, collection of liquidated damages during the agreed upon corrective action period will be suspended. The corrective action plan must include a date certain for the correction of the occurrence. Should that date for correction be missed by the Contractor, 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 as determined by SCDHHS of the occurrence has been made.

Whenever SCDHHS reasonably 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 Contractor's right to enroll new members and impose any other sanctions in accordance with §13.5. The SCDHHS, when exercising this option, shall notify Contractor in writing of its intent to suspend new enrollment. The suspension period may be for any length of time specified by SCDHHS, or may be indefinite. The SCDHHS also may notify members of Contractor non-performance and permit these members to transfer to another health plan following the implementation of suspension.

13.4 Use of Data

SCDHHS 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.

13.5 Sanctions

If SCDHHS determines that the Contractor has violated any provision of this Contract, or the applicable statutes or rules governing Medicaid prepaid health plans, the SCDHHS may impose **sanctions**~~,~~ against the Contractor~~, sanctions~~. SCDHHS 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 (~~42USC 1396u2~~ **42 U.S.C. §1396u-2**) and 42 CFR §**§**438.700-730 (2006, as amended) and may include any of the following ~~sanctions~~:

~~13.5.1 Suspension of the Contractor's acceptance of applications for Medicaid enrollment;~~

13.5.~~2~~**1** ~~Suspension or revocation of payments to the Contractor for Medicaid beneficiaries/eligibles enrolled during the sanction period; including default of the enrollment of Medicaid members. This violation may result in recoupment of capitated payment~~**Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or SCDHHS 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;**

13.5.~~3~~**2** Suspension of all marketing activities permitted under this Contract;

13.5.~~4~~**3** Imposition of a fine of up to ~~Ten~~**Twenty-five** Thousand Dollars ~~($10,000.00~~**$25,000.00**) for each marketing/enrollment violation, in connection with any one audit or investigation;

13.5.~~5~~**4** Termination pursuant to §13.2.2 of this Contract;

13.5.~~6~~**5** Non-renewal of the Contract pursuant to §13.7 of this Contract;

13.5.6 Suspension of auto-enrollment;

13.5.7 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**,** ~~and~~ grant members the right to terminate enrollment without cause~~,~~ **and** ~~notifying~~**notify** the affected members of their right to terminate enrollment~~.~~**;**

13.5.8 Civil money penalties in accordance with §1932 of the Social Security Act (42USC 1396u-2)~~.~~**;**

13.5.9 Withhold a portion or all of the Contractor's capitation payment;

13.5.~~9~~**10** Permit individuals enrolled in the Contractor's plan to ~~be disenrolled~~**disenroll** without cause. SCDHHS may suspend or default all enrollment of Medicaid beneficiaries after the date the Secretary or SCDHHS notifies the Contractor of an occurrence under §1903(m) or section 1932(e).of the Social Security Act.

13.5.~~10~~**11** Terminate **the** contract if the Contractor has failed to meet the requirements of section**s** 1903(m), 1905(t)(3) or 1932(e) of the Social Security Act and offer the Contractor's Medicaid members an opportunity to enroll with other Contractors to allow members to receive medical assistance under the State Plan. SCDHHS shall provide the Contractor a hearing before the SCDHHS Division of Appeals and Hearings before termination occurs. SCDHHS will notify the Medicaid members enrolled in the Contractor's plan of the hearing and allow the Medicaid ~~eligibles~~**members** to disenroll, if they choose, without cause~~.~~**;**

13.5.~~11~~**12 Imposition of sanctions** ~~P~~**p**ursuant to § 1932(e)(B) **of the Social Security Act**~~SCDHHS may impose sanctions against the Contractor~~ if the Contractor does not provide abortion services as provided under **the** ~~c~~**C**ontract, at § 4~~.~~**;**

13.5.~~12~~**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 ~~an~~**a** member covered under the contract.

13.5.~~13~~**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 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.

13.5.~~14~~**15** Imposition of a fine as high as double the excess amount charged to the Medicaid members by the Contractor for premiums or charges in excess of the premiums or charges permitted under Title XIX.

13.5.~~15~~**16** ~~SCDHHS may impose~~**Imposition of** sanctions as outlined in the MCO Policy and Procedure Guide if the Contractor fails to comply with the Physician Incentive Plan requirements.

13.5.~~16~~**17** ~~SCDHHS may impose~~**Imposition of** sanctions as outlined above if the Contractor misrepresents or falsifies information that it furnishes to CMS, to the State or to a member, potential member or health care provider.

~~13.6 Duration of the Sanction~~

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

13.~~7~~**6** 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~~**7** Plan of Correction Required (Contract Non-Compliance)

The Contractor and its subcontractors shall comply with all requirements of this Contract. In the event SCDHHS 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 SCDHHS outlining the steps it will take to correct any deficiencies and/or non-compliance issues identified by SCDHHS in the Notice of Corrective Action. SCDHHS shall have final approval of the Contractor's plan of correction.

The Contractor's plan of correction shall be submitted to SCDHHS within the time frame specified in the Notice of Corrective Actions. The Contractor and/or its subcontractor(s) shall implement the corrective actions as approved by SCDHHS 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 SCDHHS 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 SCDHHS shall subject the Contractor to the actions, ~~including but not limited to~~, **stated** in §§13.2, ~~including all subsections~~**, 13.3 and 13.5** including all subsections of this Contract.

13.~~9~~**8** Inspection of Records

The Contractor shall make all program and financial records and service delivery sites open to the HHS, SCDHHS, GAO, State Auditor's Office, Office of the Attorney General, Comptroller General, or their designee. HHS, SCDHHS, 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~~**9** Non-Waiver of Breach

The failure of SCDHHS at any time to require performance by the Contractor of any provision of this Contract, or the continued payment of the Contractor by SCDHHS, shall in no way affect the right of SCDHHS 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~~**10** 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 SCDHHS.

13.~~12~~**11** Legal Services

No attorney-at-law shall be engaged through use of any funds provided by SCDHHS 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), SCDHHS 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~~**12** Venue of Actions

Any and all suits or actions for the enforcement of the obligations of this Contract and for any and every breach thereof, or for the review of a SCDHHS final agency decision with respect to this Contract or audit disallowances, and any judicial review sought thereon and brought pursuant to the S.C. Code Ann. § 1-23-380 (2000, as amended) shall be instituted and maintained in any court of competent jurisdiction in the County of Richland, State of South Carolina.

13.~~14~~**13** Attorney's Fees

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

13.~~15~~**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 SCDHHS or the State of South Carolina. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any subcontractor and SCDHHS and the State of South Carolina.

13.~~16~~**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.~~17~~**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 SCDHHS and 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 SCDHHS 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.~~18~~**17** Copyrights

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

13.~~19~~**18** Subsequent Conditions

The Contractor shall comply with all requirements of this Contract and SCDHHS shall have no obligation to enroll any MCO ~~p~~**P**rogram Members into the Contractor's plan until such time as all of said requirements have been met.

13.~~20~~**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.~~21~~**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.~~22~~**21** Safeguarding Information

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

13.~~22~~**21**.1 Be comparable to those imposed upon the SCDHHS by 42 CFR Part 431, Subpart F (2005, as amended) and S.C. Code R. 126-170 et seq. (Supp. 2000, as amended);

13.~~22~~**21**.2 State that the Contractor will identify and comply with any stricter state or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

13.~~22~~**21**.3 Generally, require the written consent of the member or potential member before disclosure of information about him or her;

13.~~22~~**21**.4 Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

13.~~22~~**21**.5 Specify appropriate personnel actions to sanction violators.

13.~~23~~**22** Release of Records

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

13.~~24~~**23** Fraudulent Activity

The Contractor shall report to SCDHHS any cases of suspected Medicaid fraud or abuse by its 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 SCDHHS:

(a) the number of complaints of fraud and abuse made to ~~SCDHHS~~**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 SCDHHS Division of Program Integrity for fraud and abuse complaints regarding 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 SCDHHS 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 SCDHHS 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 SCDHHS 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 SCDHHS, (i.e., a major disaster, epidemic, complete

or substantial destruction of facilities, war, riot or civil insurrection), neither the Contractor, SCDHHS, 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 program 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 program 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 program 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 SCDHHS 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 SCDHHS both agree that the capitation rates identified in Appendix B of this Contract**. with the exception of the SSI capitation rate,** shall remain in effect during the period identified on the HMO Capitation Rates Schedule. **The SSI capitation rate shall be subject to risk adjustment and recalculated on a six month basis.** Rates may be adjusted during the contract period based on SCDHHS and actuarial analysis, and subject to CMS review and approval.

The Contractor and SCDHHS both agree that the adjustments to the capitation rate(s) required pursuant to this section shall occur only by written amendment to this Contract and should either the Contractor or SCDHHS refuse to execute the written amendment, the provisions of §13.2 of this Contract shall apply.

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.

SCDHHS shall not be liable for any excess cost to the Contractor for SCDHHS'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 SCDHHS. In all cases, the failure to perform must be beyond the control without the fault or negligence of SCDHHS.

13.34 Conflict of Interest

~~All State employees shall be subject to the provisions of S.C. Code Ann. § 8-13-100 and §8-13-310, et seq. (Supp. 2000, as amended).~~

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

SCDHHS 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 SCDHHS's action or decision which forms the basis of the appeal. Administrative appeals shall be in accordance with SCDHHS's regulations R. 126-150, et seq., Code of Laws of South Carolina (1976), Volume 27, as amended, and in accordance with the Administrative Procedures Act, §§ 1-23-310, et seq., Code of Laws of South Carolina (1976), as amended. Judicial review of any final SCDHHS administrative decisions shall be in accordance with § 1-23-380, Code of Laws of South Carolina (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 SCDHHS 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 SCDHHS 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 SCDHHS 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:

13.40.1 Organ transplants, unless the State plan has written standards meeting coverage guidelines specified;

13.40.2 Non-emergency services provided by or under the direction of an excluded individual

13.40.3 Any amount expended for which funds may not used under the Assisted Suicide Funding Restriction Act of 1997;

13.40.4 Any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan; and

13.40.5 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. ~~Employee Education about False Claims Recovery~~.

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 SCDHHS by the Contractor must be in format accessible and modifiable by the standard Microsoft Office Suite of products or in a format accepted and approved by SCDHHS.

~~13.44 County Network Termination Transition Plan~~

~~In the event an MCO county network(s) is found to be in violation of requirements stated in Section 4.8.2, Adequacy of Providers, SCDHHS shall reserve the right to implement the MCO Provider County Network Termination 90 Day Transition Plan, as described in the **MCO Policy and Procedure Guide**.~~

13.4~~5~~**44** National Provider Identifier

The HIPAA Standard Unique Health Identifier regulations (45 CFR 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 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 SCDHHS once obtained from the NPPES. Provider also agrees to use the NPI it obtained from the NPPES to identify itself on all standard transactions that it conducts with SCDHHS.

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 should 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 SCDHHS. 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 SCDHHS. 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 practitioners, 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 practitioners, 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, establish an alternative payment schedule."

REVISION XV

NOW THEREFORE, APPENDIX A, as shown in the April 1, 2008 Contract, as amended, shall now read as attached hereto and incorporated by reference as if fully set forth herein.

REVISION XVI

NOW THEREFORE, APPENDIX B, as shown in the April 1, 2008 Contract, as amended, shall now read as attached hereto and incorporated by reference as if fully set forth herein.

REVISION XVII

NOW THEREFORE, APPENDIX C, as shown in the April 1, 2008 Contract, as amended, shall now read as attached hereto and incorporated by reference as if fully set forth herein.

REVISION XVIII

NOW THEREFORE, APPENDIX D, shall be added to the April 1, 2008 Contract, as amended, shall now read as attached hereto and incorporated by reference as if fully set forth herein.

All other terms and conditions as set forth in the April 1, 2008 Contract, as amended, not expressly addressed in this Amendment shall remain the same and in full force and effect.

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IN WITNESS WHEREOF, the SCDHHS and the Contractor, by their authorized agents, in consideration of the mutual promises, covenants, and conditions exchanged between them, have executed this Amendment to be effective as of the first day of October 2009.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES "SCDHHS"	«providercaps» "Contractor"
BY: _____	BY: _____
Emma Forkner Director	Authorized Signature
	_____
	Print Name
WITNESSES:	WITNESSES:
_____	_____
_____	_____

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LIST OF APPENDICES

A. Definitions

B. Capitation Rates and Reimbursement Methodology

C. HIPAA Business Associate Terms

D. Pay for Performance

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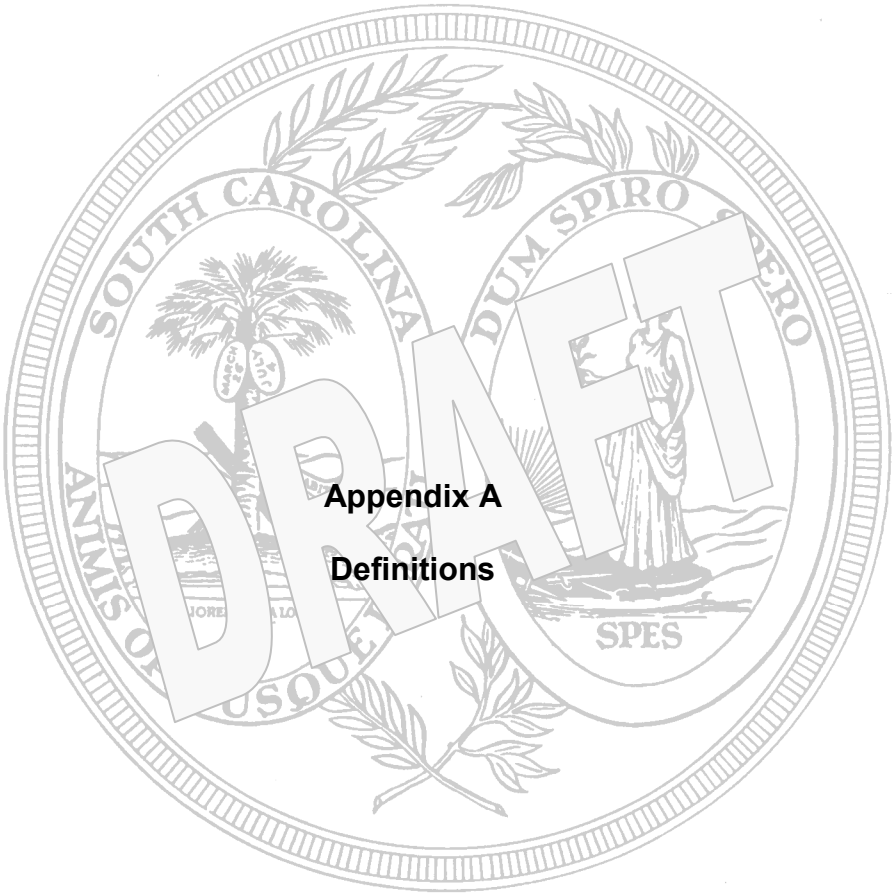

Appendix A

Definitions

DEFINITION OF TERMS

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 – Means 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.

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.

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.

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 SCDHHS 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 which describes services and supplies provided to Medicaid MCO program member, 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 SCDHHS 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 is 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 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 Medicaid Plan.

Contractor - The domestic licensed MCO that has executed a formal agreement with SCDHHS 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.

Disenrollment - Action taken by SCDHHS 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 SCDHHS or its designee that the member is no longer eligible or 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.

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

Dual Diagnosis/Dual Disorders - An individual who has both a diagnosed mental health problem together with problems of 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 Title XIX SC State Medicaid Plan.

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 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 Data – Any service provided to a Medicaid MCO Program member regardless of who provides the service used in accumulating utilization data. This includes preventive, diagnostic, therapeutic, and any other service provided to the member~~.

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 ~~either~~ DHHS ~~or the MCO's Department of Insurance (DOI) licensed marketing representative~~ **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 their contractors furnish to Medicaid recipients.

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

Expanded Services - A covered service provided by the Contractor which is currently a non-covered service(s) by the State Medicaid Plan 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.

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 is certified by the Centers for Medicare and Medicaid Services and 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 under served 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 of some other person. It includes any act that constitutes fraud under applicable Federal or State law.

GAO - General Accounting Office.

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-9-CM - International Classification of Disease, **Clinical Modification, 9th Edition**, 2008.

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 - A person incarcerated in or otherwise confined to a correctional institution (i.e., jail). 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 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 § 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 service 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 SCDHHS, 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 reasonable 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 SCDHHS which accepts payment in full for providing benefits, the amounts paid 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 Medicaid MCO Program member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

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

NCQA- The National Committee for Quality Assurance is a private, non-for-profit organization founded in 1990, which sets Medicare, Medicaid, and private insurance HEDIS measurements. They have accreditation and certification programs for different types of health providers and health assessment products.

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 Title XIX SC State Medicaid Plan.

Non-Emergency - An encounter by a Medicaid MCO Program member who has presentation of medical signs and symptoms, to a health care provider, and not requiring 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 stock, equity in the capital, or any interest in the profits of the Contractor. For further definition see 42 CFR 455.101 (2005).

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

Policies - The general principles by which SCDHHS is guided in its management of the Title XIX program, as further defined by SCDHHS promulgations and by state 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 – All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Provider (PCP) - The provider who serves as the entry point into the health care system for the member. The PCP is responsible for including, but not limited to providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining the 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 Title XIX SC State Medicaid Plan and SCDHHS regulations.

Provider – Either (1) for the Fee-For-Service Program, any individual or entity furnishing Medicaid services under an agreement with the Medicaid agency; or (2) for the Managed Care Program, any individual or entity 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 it pertains to external quality review, means the degree to which an MCO increases the likelihood of desire health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge.

Quality Assessment - The process of assessing the delivery of health care services provided to members are appropriate, timely, accessible, available, desirable outcomes and medically necessary.

Recipient - A person who is determined eligible in receiving services as provided for in the Title XIX SC State Medicaid Plan.

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 Section 5:

- A director, officer, or partner of the MCO;
- A person with beneficial ownership of five percent or more of the MCO's equity; or
- A person with an employment, consulting or other arrangement (e.g., providers) with the MCO obligations 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 receives Public Health Services grants. An RHC is eligible for state defined cost based reimbursement from the Medicaid fee-for-service program. An RHC

provides a wide range of primary care and enhanced services in a medically under served 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 by SCDHHS 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 - Is 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.

SCDHHS - South Carolina Department of Health and Human Services

SCDHHS Appeal Regulations - Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 at S.C. Code Regs. 126-150 et seq. and S.C. Code Ann. §§1-23-310 et seq. (2006, as amended).

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, SCDHHS regulations, and SCDHHS regulations.

South Carolina State Plan for Medical Assistance - A plan, approved by the Secretary of SCDHHS, 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 Contract agreement between the Contractor and a third party to perform a specified 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 SCDHHS 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 who 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, routine follow-up to a previously treated condition or illness, adult and/or any other routine visit for other than the treatment of an illness.

WIC - The Supplemental Food Program for Women, Infants, and Children which provides nutrition counseling, nutrition education, and nutritious foods to pregnant and postpartum women, infants, and children up to the age of two or children deemed nutritional deficient are covered up to age five who have a low income and who are determined to be at nutritional risk.

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Appendix B

Capitation Rates and Reimbursement Methodology

South Carolina
Department of Health and Human Services
MCO Capitation Rates

Effective October 1, 2009 – March 31, 2010
(Universal-Standard)

Aid Category	PMPM
Family:	
< 1 Males & Females	~~$328.16~~
1 – 6 Males & Females	103.89
7 – 13 Males & Females	~~88.90~~
14 – 18 Males	~~91.76~~
14 – 18 Females	~~128.56~~
19 – 44 Males	~~227.51~~
19 – 44 Females	~~294.33~~
45 & Older Males & Females	~~495.72~~
OCWI Women	~~392.83~~
SSI & SSI Related, w/o Medicare	~~764.08~~
Maternity Kicker Payment	~~5,774.20~~
Newborn Kicker Payment	~~1,744.57~~

OCWI = Optional Coverage for Women and Infants
SSI = Supplemental Security Income

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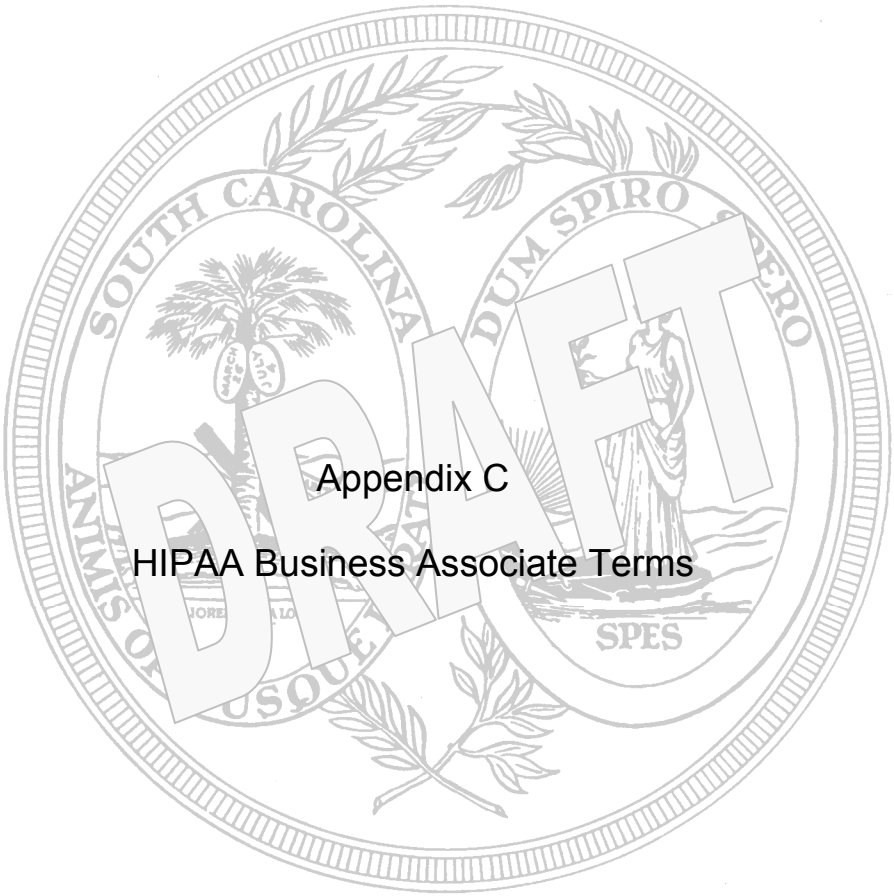

Appendix C

HIPAA Business Associate Terms

~~HIPPA 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, but not otherwise defined, in this Section shall have the same meaning as those terms in the HIPAA Privacy Rule.~~

1. ~~Business Associate. "Business Associate" shall have the same meaning as the term "business associate" in 45 CFR § 160.103 (2002)~~

2. ~~Covered Entity. "Covered Entity" shall mean SCDHHS.~~

3. ~~Individual. "Individual" shall have the same meaning as the term "individual in 45 CFR § 164.501 (2002) and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.502 (2002)~~

4. ~~Privacy Rule. "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E (2002)~~

5. ~~Protected Health Information. "Protected Health Information" shall have the same meaning as the term "protected health information" in 45 CFR § 164.501 (2002), limited to the information created or received by Business Associate from or on behalf of Covered Entity.~~

6. ~~Required By Law. "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.501 (2002).~~

7. ~~Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.~~

8. ~~Security Standard shall mean the Security Standards at 45 C.F.R. Part 160 and Part 164, as may be amended.~~

9. ~~Electronic PHI shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.~~

10. ~~Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interface with system operations in an information system or its current meaning under 45 C.F.R. § 164.304.~~

~~C. Business Associate Agrees to:~~

1. ~~Not use or disclose PHI other than as permitted or required by the Contract or as Required By Law.~~

2. ~~Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for in this Appendix.~~

3. ~~Mitigate to the extend practicable, any harmful effect know to BUSINESS ASSOCIATE if BUSINESS ASSOCIATE uses/disclosures PHI in violation of this Appendix.~~

4. ~~Report to COVERED ENTITY any use or disclosure of the PHI not provided for in this Appendix of which it becomes aware.~~

5. ~~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.~~

6. ~~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.~~

7. ~~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.~~

8. ~~Make internal practices, books, and records, including policies and procedures and PHI, relating to the use and disclosure of PHI received form, 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.~~

9. ~~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.~~

10. ~~Provide to COVERED ENTITY or an Individual, in time and manner designated by COVERED ENTITY, information collected in accordance with Section C.9 of this Appendix, to permit COVERED ENTIY to respond to a~~

~~request by an Individual for an accounting of disclosure of PHI in accordance with 45 CFR § 164.528.~~

11. ~~Business Associate understands and agrees that, should SCDHHS be found in violation of the HIPAA Privacy Rule due to business associate's material breach for this Section, business associate shall be liable to SCDHHS for any damages, penalties and/or fines assessed agains 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 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 to 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 I. 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 ENTIY 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 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 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. ~~The rights and obligations of BUSINESS ASSOCIATE under Section F.3. shall survive the termination of the Contract.~~

4. ~~Any ambiguity in this Appendix shall be resolved to permit COVERED ENTITY to comply with the Privacy Rule.~~

HIPAA BUSINESS ASSOCIATE

A. <u>Purpose</u>

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 (Other terms used but not defined shall have the same meaning as those terms in the HIPAA Privacy Rule.)

1. Business Associate means the same as "business associate" in 45 CFR § 160.103.

2. Covered Entity means SCDHHS.

3. Designated Record Set means the same as "designated record set" in 45 CFR § 164.501.

4. Individual means the same as "individual" in 45 CFR § 160.103 and includes a person who qualifies as a personal representative in accordance with 45 CFR § 164.502(g).

5. Privacy Rule means the HIPAA Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 160 and Part 164, Subparts A and E).

6. Protected Health Information (PHI) means the same as the term protected health information in 45 CFR § 160.103, limited to information received by Agency from Covered Entity.

7. Required By Law means the same as "required by law" in 45 CFR § 164.103, and other law applicable to the PHI disclosed pursuant to the Contract.

8. Secretary means the Secretary of the Department of Health and Human Services or designee.

9. Security Standards shall mean the Security Standards at 45 C.F.R. Part 160 and Part 164, as may be amended.

10. Electronic PHI shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. § 160.103.

11. 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 or its current meaning under 45 C.F.R. § 164.304.

C. Business Associate Provisions

Business Associate agrees to:

1. **Not use or disclose PHI other than as permitted or required by the Contract or as required by law.**

2. **Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for in the Contract.**

3. **Mitigate to the extent practicable, any harmful effect known to Business Associate if it uses/discloses PHI in violation of the Contract.**

4. **Immediately report to Covered Entity any breaches in privacy or security that compromise PHI. 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 should include a detailed description of the breach and any measures that have been taken by the Business Associate to mitigate the breach.

   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.

5. **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.**

6. **If the Business Associate has PHI in a designated record set: (1) provide access at Covered Entity's request to PHI to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR § 164.524; (2) make any amendment(s) to PHI in a designated record set that Covered Entity directs or agrees to pursuant to 45 CFR § 164.526.**

7. **Make its internal practices, books, records, and policies/procedures relating to the use/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.**

8. **Document Business Associate disclosures of PHI, other than disclosures back to Covered Entity, and related information as would be required for Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.**

9. **Provide to Covered Entity or an individual, as designated by Covered Entity, information collected in accordance with Section C.8 of this Appendix, to permit Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR § 164.528.**

10. **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.**

11. **Otherwise, not re-disclose Covered Entity PHI except as permitted by applicable law.**

12. **Be liable to Covered Entity for any damages, penalties and/or fines assessed against Covered Entity should Covered Entity be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this section. Covered Entity is authorized to recoup any and all such damages, penalties and/or fines assessed against Covered Entity by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which Covered Entity 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 Covered Entity, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.**

D. **<u>Permitted Uses and Disclosures by Business Associate</u>**

1. **Except as limited in the Contract, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use would not violate the Privacy Rule if done by Covered Entity or Covered**

Entity's privacy practices. Unless otherwise permitted in this Appendix, in the Contract or required by law, Business Associate may not disclose/re-disclose PHI except to Covered Entity.

2. Except as limited in this Appendix, Business Associate may use/disclose PHI for 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 its services under the 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 to appropriate Federal or State authorities as permitted by § 164.502(j)(1).

E. <u>Covered Entity Provisions</u>

Covered Entity agrees to:

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/disclose PHI in any manner not permitted under the Privacy Rule if done by Covered Entity.

F. <u>Term and Termination</u>

1. The terms of this Appendix shall be effective immediately upon signing of the Contract 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 its knowledge of a material breach by Business Associate, Covered Entity shall either:

a. Allow 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. <u>Effect of Termination</u>

a. Except as provided in paragraph (2) below, upon termination of the Contract, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision also applies to PHI in the possession of Business Associate's subcontractors or agents. Business Associate shall retain no copies of the PHI.

b. If Business Associate determines that returning the PHI is infeasible, Business Associate shall notify Covered Entity 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. <u>Security Compliance</u>

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 and all regulations promulgated under HIPAA. Additionally, Business Associate will immediately report to Covered Entity any Security Incident of which it becomes aware.

H. <u>Miscellaneous</u>

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. **The respective rights and obligations of Business Associate under Section F. 3. shall survive the termination of the Contract.**

4. **Any ambiguity in this Appendix shall be resolved to permit Covered Entity to comply with the Privacy Rule.**

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Appendix D

Pay For Performance

APPENDIX D

PAY FOR PERFORMANCE

Except as defined below or the context requires otherwise, all capitalized terms shall have the meanings ascribed to them in the Contract.

Program Establishment and Eligibility. SCDHHS plans to institute a pay for performance program in calendar year 2011. Under this program, the Contractor may receive additional compensation if certain conditions are met. Compensation under the pay for performance program is subject to the Contractor's complete and timely satisfaction of its obligations under the Contract. This includes but is not limited to timely submission of the Contractor's HEDIS Report for the measurement year and the Certified HEDIS Compliance Auditor's attestation. The Contractor must collect and report HEDIS data as set forth below for calendar year 2011. This data must be certified by NCQA.

Performance Measures. SCDHHS has tentatively identified the following measures for performance improvement and incentive payments. SCDHHS reserves the right to amend this list prior to implementation of the pay for performance program in calendar year 2011. Each item will be measured during calendar year 2011 for determining the Contractor's eligibility for incentive payments.

- **Cervical Cancer Screening (HEDIS Code CCS)**
- **Breast Cancer Screening (HEDIS Code BCS)**
- **Appropriate Treatment for Children With Upper Respiratory Infection (HEDIS Code URI)**
- **Comprehensive Diabetes Care—LDL-C Screening, Eye Examination, HbA1c Testing, Nephropathy Monitoring (HEDIS Code CDC)**
- **Well Child Visits (0-15 months)—Six or more visits (HEDIS Code W15)**
- **Well-child Visits (3-6 years)—One or more visits (HEDIS Code W34)**
- **Adolescent Well-care Visits (12-21 years)—One or more visits (HEDIS Code AWC)**
- **Prenatal and Postpartum Care (HEDIS Code PPC)**
- **Use of Appropriate Medications for People with Asthma (HEDIS Code ASM)**
- **Follow-Up Care for Children Prescribed ADHD Medication (HEDIS Code ADD)**
- **Ambulatory Care - Outpatient and ER Visits (HEDIS Code AMB)**
- **Colorectal Cancer Screening (HEDIS Code COL)**

Performance measures may change on a year-to-year basis as program priorities shift and as necessary to support continuous quality improvement in the Healthy Connections Choices program. The performance measures applicable during subsequent years of the Contract will be established annually by SCDHHS and reflected in an amendment to the Contract.

Additional Measures. In addition to the twelve (12) performance measures outlined in Section 1 of this Attachment, SCDHHS will monitor the Contractor's performance as it relates to nineteen (19) additional measures and targets listed in the MCO Policy and Procedure Guide.

Non-Financial Incentives. In addition to the potential to earn incentive payments based on performance in the identified areas, SCDHHS may establish other means to incent performance improvement. SCDHHS intends to distribute information on key performance indicators to participating managed care plan contractors and the public on a regular basis, identifying the Contractor's performance, and comparing that performance to other managed care plan contractors, standards set by SCDHHS and/or external benchmarks or industry standards. SCDHHS will recognize managed care plan contractors that attain superior performance and/or improvement by publicizing their achievements. For example, SCDHHS may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public. SCDHHS retains the right to publish Consumer Assessment of Healthcare Providers and Systems (CAHPS) data.

SCDHHS may also revise its auto-assignment methodology during the Contract period for new members who do not select a participating managed care plan contractor. The new assignment methodology would reward those contractors that demonstrate superior performance and/or improvement on one or more performance measures described in Section 3 above. SCDHHS may also make managed care plan contractor performance results available to new Healthy Connections Choices members during the primary care provider (PCP) and managed care plan contractor selection process.