



**Policy and Procedures Guide
For
Care Coordination Service Organizations
(MEDICAL HOMES Networks)**



April 1, 2011

TABLE of CONTENTS

1.0	INTRODUCTION	1
2.0	THE CSO CONTRACT PROCESS	3
2.1	REQUIRED SUBMISSIONS	5
2.2	READINESS REVIEW	7
2.3	CSO PROVIDER (SUBCONTRACTS) NETWORK	7
2.4	CSO / SUBCONTRACTOR OWNERSHIP DISCLOSURE.....	8
2.5	PROVIDER COUNTY NETWORK APPROVAL PROCESS	8
2.6	REQUIREMENTS FOR THE UTILIZATION OF NURSE PRACTITIONERS (NPs) AS PROVIDERS OF HEALTH CARE SERVICES.....	10
3.0	THE SUBCONTRACT PROCESS	11
3.1	CHANGES TO APPROVED MODEL SUBCONTRACTS.....	11
3.2	SUBCONTRACT UPDATE PROCESS.....	12
3.3	CSO COMMUNICATIONS REGARDING SUBCONTRACT TERMINATION.....	12
3.4	CSO NETWORK TERMINATION / TRANSITION PROCESS.....	13
3.5	SUBCONTRACTOR REQUIREMENTS	14
3.6	24-HOUR COVERAGE REQUIREMENT	14
3.7	STANDARDS OF APPOINTMENT AVAILABILITY	15
3.8	STANDARDS FOR OFFICE WAIT TIMES.....	15
3.9	HOSPITAL ADMITTING PRIVILEGES REQUIREMENT.....	15
3.10	MEDICAL RECORDS	15
3.11	TRANSFER OF MEDICAL RECORDS.....	16
4.0	QUALITY ASSESSMENT AND UTILIZATION MANAGEMENT REQUIREMENTS.....	16
5.0	MEDICAID ELIGIBILITY	25
5.1	MEDICAID ELIGIBILITY DETERMINATION.....	25
5.2	INFANTS AND MEDICAID ELIGIBILITY.....	25
5.3	ANNUAL REVIEW – MEDICAID ELIGIBILITY REDETERMINATION.....	26
6.0	MANAGED CARE ENROLLMENT	27
6.1	MHN ENROLLMENT RESTRICTIONS.....	27
6.2	MANAGED CARE ENROLLMENT OF NEWBORNS.....	28
7.0	MANAGED CARE DISENROLLMENT / TRANSFER.....	29
7.1	MEDICAID MHN MEMBER-INITIATED DISENROLLMENT OR TRANSFER	30
7.2	CSO INITIATED DISENROLLMENT	31
8.0	PAYMENTS AND ADJUSTMENTS	32
8.1	MHN SHARED SAVINGS FORMULA POLICY	32
8.2	SANCTIONS.....	33

TABLE of CONTENTS

8.3	PER MEMBER PER MONTH PAYMENT ADJUSTMENT	33
8.4	PAYMENT RESPONSIBILITY FOR HOSPITAL STAYS WHEN ENROLLMENT/DISENROLLMENT OCCURS.....	33
9.0	GRIEVANCE AND APPEALS.....	33
10.0	PRIOR AUTHORIZATIONS AND REFERRALS.....	34
10.1	REFERRAL DOCUMENTATION.....	35
10.2	SERVICES NOT REQUIRING A REFERRAL	35
10.3	MEDICAID MHN MEMBER BILLING.....	36
11.0	MEMBER BENEFITS.....	36
12.0	MARKETING / ADVERTISING AND MEDICAID MHN MEMBER EDUCATION	37
12.1	ACTIVITIES WHICH ARE NOT PERMITTED.....	40
12.2	MARKETING EVENTS AND ACTIVITIES	41
12.3	FOCUS GROUPS AND MEMBER SURVEYS	41
12.4	MEMBER SERVICES	42
12.5	ENROLLMENT INCENTIVES.....	42
13.0	COORDINATION OF MANAGED CARE FRAUD AND ABUSE COMPLAINTS AND REFERRALS	43
14.0	INDEX OF REQUIRED FILES, REPORTS, AND FORMS.....	45
15.0	DEFINITION OF TERMS.....	47
APPENDICES		54
APPENDIX 1 —	COUNTY LISTING	55
APPENDIX 2 —	MEMBERS' AND POTENTIAL MEMBERS' BILL OF RIGHTS.....	56
APPENDIX 3 —	PROVIDERS' BILL OF RIGHTS.....	58
APPENDIX 4 —	TRANSPORTATION BROKER LISTING AND CONTACT INFORMATION.....	59

MEDICAL HOMES NETWORK PROGRAM

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

1.0 INTRODUCTION

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

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

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

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

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

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

The MHN healthcare delivery model is SC Healthy Connections (SCHC) Primary Care Case Management (PCCM) program linking Medicaid MHN Members with a Primary Care Provider (PCP). SCDHHS contracts with a Care Coordination Service Organization (CSO) who, in turn, subcontracts with PCPs to serve as the Medicaid MHN Member's medical home.

The PCP works in partnership with the member to provide and arrange for most of the member's health care needs, including authorizing services provided by other health care professionals. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management, and data management.

All providers participating in an MHN must be enrolled in SCHC (Medicaid), as all services are paid on a fee-for-service (FFS) basis. The outcomes of this medical home initiative have been healthier, better-educated Medicaid beneficiaries, and cost savings for South Carolina through a reduction of acute medical care and disease related conditions.

Medicaid MHN Members have care managers who assist in developing, implementing, and evaluating the care management strategies of the Network. These care management strategies include:

- Risk assessment process – utilizing an “at risk” screening tool that identifies both medical and social risk factors
- Reviewing emergency department utilization – integrating appropriate outreach, follow-up, and educational activities based on emergency department use by members
- Implementing disease management processes – for example, targeting pediatric and adult asthma, sickle cell anemia, congestive heart failure, and diabetes
- Implementing a care management process – identifying and targeting care management activities based on the screening process and other methods of identifying those members at risk
- Identifying high costs and high users – developing and implementing activities that impact utilization and cost

The Division of Managed Care is responsible for the formulation of medical and Program policy, interpretation of these Policies and oversight of Quality and utilization management requirements set forth in this chapter. CSOs in need of assistance to locate, clarify, or interpret medical or Program Policy should contact the Division of Managed Care at the following address:

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

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

2.0 THE CSO CONTRACT PROCESS

This section of the guide is designed to provide the information necessary for preparing to initiate a Medical Homes Network (MHN) contract with the SCDHHS. SCDHHS will furnish potential Care Coordination Service Organizations (CSOs) wishing to operate as an MHN with a copy of the MHN model contract upon request. This contract may also be found on the SCDHHS Web site at www.scdhhs.gov. The terms of the contract are established and are not negotiable.

SCDHHS will not contract with any individual and/or group of individuals having an outstanding debt with the agency. If any member of a group has an outstanding debt against SCDHHS, the entire group will be considered to have the same. South Carolina also will not contract with any group or individual who are on the USDHHS exclusion list.

The potential CSO should send a letter requesting inclusion, participation, and enrollment in the MHN Program. The letter should be addressed to:

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

Upon receipt of this letter, SCDHHS will contact the potential CSO and request the following information sent in an application packet:

1. Business Plan
2. Ownership Disclosure (regardless of percentage of ownership)

Note: Should the ownership change prior to or after the CSO executes a contract with SCDHHS, the CSO will report all ownership regardless of percentage

3. Board Member Names and Qualifications

4. Officer Names and Qualifications
5. Financial Statements (bank account, line(s) of credit, loans)
6. Office Location (physical address)

The above information must be housed in a binder with an attached USB flash drive of all materials. The number of binders (copies) and flash drives will be determined by SCDHHS.

After submission of an application packet, SCDHHS will develop a project plan to include all elements potential CSOs will need to complete in order to contract as a South Carolina Medicaid Managed Care Provider. Included with the project plan will be the requirement of the CSO to coordinate with the SCDHHS Division of MMIS to establish connectivity with the SCDHHS information system(s).

At the appropriate time, SCDHHS will authorize its External Quality Review Organization (EQRO) to begin a readiness review of the CSO's South Carolina operation. If deficiencies are noted during the review, the CSO will be required to submit a Corrective Action Plan (CAP) to SCDHHS. Time frames given for correcting deficiencies will be based on the severity and scope of the deficiencies.

Following the EQRO review, SCDHHS will mail an enrollment package to the potential CSO in accordance with the project planner time frame. The enrollment package will contain the following:

1. Two (2) copies of the contract
2. Enrollment Form (DHHS Form 219-HMO)
3. Minority Business Form
4. Disclosure of Ownership & Control Interest Statement Form SCDHHS 1513 (02/09)
5. Form W-9, Taxpayer Identification Number and Certification
6. Drug Free Workplace Form
7. EFT Authorization Form
8. Certification Relating to Restrictions on Lobbying
9. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion – Lower tier Covered Transactions
10. Nonresident Taxpayer Registration Affidavit
11. Copy of the MHN Policy and Procedures Guide

2.1 Required Submissions

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

A. Organizational Requirements

1. A copy of any current or pending administrative legal action or Grievance filed by the Subcontractor or the Medicaid MHN Member, including the dates of initiation and resolution.
2. A copy of any current or pending administrative legal action or Grievance of person(s) convicted of criminal offense, including the dates of initiation and resolution
3. A list of staff liaisons. Please include the name, title, and telephone number of the designated individual for the following:
 - Liaison Staff Contact
 - Medical Director Contact
 - Senior Management Contact
 - QA Contact
 - Reporting Contact

B. CSO Provider Network Requirements

1. A copy of the recruitment plan and process for obtaining a comprehensive Provider network:
 - a. Include strategies for obtaining services in underserved areas, working cooperatively with existing hospital-owned networks and other challenges specific to South Carolina
2. A listing of potential network Provider Subcontractors
3. A copy of the model Primary Care Provider Subcontract boilerplate
4. A copy of the plan to educate Providers on the PCCM model of care
5. A copy of the plan used to retain subcontracted Providers at a level necessary to support Medicaid MHN Member access

The CSO must provide written documentation stating it has checked the Excluded Parties List administered by the General Services Administration, the date the inquiry(ies) was performed, and the findings contained. This documentation must be kept in the Subcontractor's file maintained by the CSO.

C. Service Delivery Requirements

1. A description of any additional services offered for Medicaid MHN Members
2. A copy of the CSO's Policies and procedures specific to service delivery to include, but not limited to:
 - a. Referral management
 - b. Care coordination
 - c. Drug utilization review
 - d. Disease management
 - e. Post Utilization review
 - f. Process for in/out of network services
3. A copy of all forms used in support of service delivery
4. A copy of written emergency room service Policies, procedures, protocols, definitions, criteria for authorization/denial of emergency room services and triage system.
5. A copy of Medicaid MHN Member PCP selection/transfer procedures and forms.
6. A copy of reports and/or processes used to measure Subcontractor and Medicaid MHN Member satisfaction
7. A description of the CSO's ability to monitor and evaluate Subcontractor service utilization and progress on program outcomes (Submit sample reports)
8. A description of the CSO's ability to manage and analyze Medicaid MHN Member and Subcontractor demographic, utilization, and cost data (Submit sample reports)

D. Quality Assessment and Performance Improvement

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

E. Marketing and Member Education

The CSO must provide written documentation describing:

1. The process used to educate the Medicaid MHN Members and/or their caregivers regarding:
 - Child development and childhood diseases
 - Health conditions specific to the Medicaid MHN Member

2. The CSO's projected maximum Medicaid MHN Member Enrollment levels
3. A copy of the CSO's written marketing plan and materials, to include Beneficiary and Medicaid MHN Member education materials, the Medicaid MHN Member handbook, Grievance and appeals materials, and advertising materials.

F. Reporting

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

2.2 Readiness Review

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

2.3 CSO Provider (Subcontracts) Network

Upon receipt of a completed enrollment package and required submissions, Managed Care staff will begin to review the CSO's county network submissions and determine if the county submission(s) meet adequacy and access standards. Along with the county network submissions, the CSO must provide an attestation letter signed by an officer of the CSO, confirming all Provider Subcontracts are in compliance with the following requirements:

- Have been prior approved by SCDHHS, also includes any amendments
- Have been properly signed and have an effective date not to begin prior to the effective date of the CSO's contract with SCDHHS
- Include approved hold harmless language
- Cover the services specified in the county network submissions
- Contain, as appropriate, suitable documentation regarding hospital privileges, credentialing information and a listing of group practice members

- Are, at a minimum, one year (12 months) in term. (Subcontracts may be renewed after the first term using a contract amendment; however, the total contract period may not exceed a maximum of five (5) years including the initial term.)

The CSO will be eligible for Medicaid MHN Member enrollment following SCDHHS approval of the networks. Timeframes for Medicaid MHN Member Enrollment will be determined and referenced on the project plan.

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

2.4 CSO / Subcontractor Ownership Disclosure

Subcontractors shall disclose to the CSO information related to ownership and control, significant business transactions, and persons convicted of crimes as required under the SCDHHS Contract, SCDHHS Policy and Procedure Guide, and 42 CFR §§ 455.104, 455.105 and 455.106 (2009, as amended). Such information shall be disclosed on the SCDHHS Form 1513 and/or such other format as may be required by SCDHHS or CMS. Subcontractors must report any changes of ownership and disclosure information at least thirty (30) calendar days prior to the effective date of the change.

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

CSOs are required to have all subcontractors fill out an ownership disclosure form prior to execution of the contract (agreement). Additionally, CSOs must verify the Subcontractor’s information at least yearly on the date of execution of the contract (agreement).

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

2.5 Provider County Network Approval Process

The following guidelines are used in the review and approval of a CSO’s Provider networks. Any changes (terminations/additions) to a CSO’s network in any county are evaluated by the Division of Managed Care using the same criteria. At a minimum, there must be at least one (1) Primary Care Provider (PCP) per every 2,500 Medicaid MHN Members.

Due to the structure of the PCCM model, CSO's may only contract with Primary Care Providers (PCP). SCDHHS identifies the following Provider types as PCP:

- Family/General Practice
- Internal Medicine
- Pediatrics
- RHC's/FQHC's
- OB/GYN (pregnant women only)
- Nurse Practitioners (see section 2.6 for guidelines)

Subcontracts are required with all Providers of service unless otherwise approved by SCDHHS. Subcontracts must be completed and executed for a period of no less than one (1) year. SCDHHS will not accept Letters of Agreements (LOA), Memorandum of Understanding (MOU), or any variations of these types of agreements.

The CSO and its network of Subcontractors shall ensure access to healthcare services for Medicaid MHN Members of all ages in accordance with the Medicaid contract. Established medical community standards in the provision of services under the contract, as well as factors such as distance traveled, waiting time, length of time to obtain an appointment, and after-hours care must be considered and meet established guidelines. SCDHHS requires the providers be located in the county the serve on a full time bases (i.e., three (3) of out of five (5) business days a week in that county. Also the CSO must should they can provide the full range of services need to all age levels of the Medicaid MHN Members.)

The CSO is responsible for ensuring all enrolled Subcontractors are eligible to participate in the South Carolina Medicaid Program. If a Subcontractor is not accepting new Medicaid MHN Members, the Subcontractor cannot be listed on the County Network Spreadsheet. Additionally if a PCP does not have admitting privileges to at least one of the Hospital(s) in the area, the PCP must provide to the CSO a detailed description of the mechanisms used to provide services to Medicaid MHN Members. This information must be kept in the Subcontractor's file maintained by the CSO. SCDHHS reserves the right to disapprove any Provider Network submission based on the information provided.

The CSO shall check the List of Excluded Individuals/Entities (LEIE) and other applicable federal reporting sources to ensure compliance with the MHN contract as frequently as required by SCDHHS. The CSO shall only submit Subcontractors who have completed the CSO application process and executed the CSO subcontract.

Using the Network Provider and Subcontractor Listing Spreadsheet, the Division of Managed Care examines the listing for the inclusion and availability of provider types for

the following categories of service: Primary Care for both adult and pediatric populations (age 0 – 99). If SCDHHS determines a network is not adequate, the CSO will be notified by e-mail the network is not approved and the specific reasons for the decision. The CSO must resubmit the complete county network for consideration once the reasons for disapproval have been corrected and highlighting the additional providers added after the original denied submission.

If SCDHHS determines the CSO has submitted an adequate county network, the Division of Managed Care will approve the network, set the effective date for enrollment and notify the CSO by e-mail. SCDHHS will also take the necessary steps to update the necessary systems and notify the appropriate departments, to include the enrollment and transportation brokers of the addition of approved counties.

Upon SCDHHS approval of a network, the CSO must maintain its adequacy and cannot refuse to accept new Medicaid MHN Members; change their new patient indicator on the Provider file; or limit Medicaid MHN Member choice of Providers without prior approval by SCDHHS, under penalty of sanctions and/or damages. SCDHHS may modify the auto assignment, or member choice processes, at its discretion.

If a CSO requests to limit auto assignment and/or member choice to any county, SCDHHS will re-evaluate the adequacy of the county network. The CSO must provide all financial and any other details in format requested by SCDHHS. As a result of this review, SCDHHS reserves the right to rescind its approval of the affected county(ies) and institute a transition plan to move the CSO's Medicaid MHN Members to other managed care options. SCDHHS reserves the right to close down the county requested but also any and additional counties at its discretion for at least one (1) year period. The affected CSO will pay all costs and charges associated with the transition plan.

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

At its discretion, SCDHHS may request the CSO to provide copies (electronic or paper) of all original contracts and rate information at no cost to SCDHHS. CSO must deliver the requested documentation to SCDHHS no later than noon (12 PM ET) the next business day. SCDHHS may, at its discretion, may contact Subcontractors to verify the accuracy of the information submitted by the CSO.

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

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

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

CSOs must:

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

CSOs must:

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

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

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

3.0 THE SUBCONTRACT PROCESS

3.1 Changes to Approved Model Subcontracts

Should a CSO modify a previously approved Subcontractor boilerplate it must submit, in the format required by SCDHHS, an electronic redlined version of the Subcontract to SCDHHS for approval prior to execution by either party. The electronic redlined Subcontract submission must contain the following information:

- All requested language changes and deviations from the approved Subcontract boilerplate

- Headers, reimbursement pages, information on Subcontractor facility(ies) including locations, Provider information including location(s), attachments or amendments, and the projected execution date of the Subcontract (all information must be complete and final)
- Footer information containing the original model Subcontract approval number and date

Once the redlined Subcontract has been given tentative approval by SCDHHS, the footer information will be changed to a tracking number provided by SCDHHS. The CSO must submit a black-lined copy of the tentatively approved redlined Subcontract for final approval. Once final approval has been given, the CSO and Subcontractor may execute the Subcontract.

CSOs are required to update their Subcontractor boilerplates on an annual basis and/or after changes have been made to the SCDHHS contract. These updates must be submitted to SCDHHS for approval within forty-five (45) calendar days after the new contract or amendment with SCDHHS has been signed by the CSO. In no case can a CSO contract with a subcontracted provider exceed a total of five (5) years. After the fourth (4th) year of a subcontract the CSO must be in talks with the subcontract and replace the current approved subcontract with a new approved boilerplate by prior to the end of the fifth (5th) year.

3.2 Subcontract Update Process

CSOs must update active executed Subcontracts to current contract standards no less than every five (5) years from their effective date. CSOs will identify the Subcontracts in need of updating and provide a list to their SCDHHS program manager quarterly. CSOs are allowed no more than twelve (12) months to complete this update process and report the final disposition to SCDHHS.

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

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

3.3 CSO Communications Regarding Subcontract Termination

The SCDHHS MHN program manager must be included in all subcontract termination notification correspondence (either written or electronic) regardless of initiating party. Should the CSO amend any portion of its subcontract with a Provider, the amendment must be approved by SCDHHS at least thirty (30) days prior to the amendment being sent to the Provider.

3.4 CSO network Termination / Transition Process

The loss of a Subcontractor in a county could compromise the CSO's ability to deliver PCCM services to its Medicaid MHN Members in compliance with federal regulations and contractual obligations with SCDHHS. This could ultimately result in 1) the SCDHHS-supervised transition to acceptable alternate Providers, or 2) the termination of the CSO's authority to serve the Medicaid MHN Members of one or more counties.

There are three ways in which the Network Termination or Transition Process can be initiated:

1. SCDHHS Care Management staff receives verbal and written notification from the CSO, along with a copy of the termination letter from the essential Provider(s). A copy of the termination letter must be provided to SCDHHS within twenty-four (24) hours of receipt of essential Provider(s)'s intent to terminate its contract(s) with the CSO. All termination must occur at the end of the month of termination, since the CSO has been compensated for a full month of services for each Medicaid MHN Member.
2. SCDHHS Care Management staff receives verbal or written notification directly from essential Provider(s) of its intent to terminate its contract with the CSO. SCDHHS will notify the CSO in writing (by letter or e-mail) within twenty-four (24) hours of receipt of the essential Provider's intent to terminate.
3. Should SCDHHS determine the CSO does not meet the network adequacy standards contained in the CSO contract and/or this Policy and Procedure Guide following the annual review of the Provider Network Listing Spreadsheet or during a review conducted at the discretion of SCDHHS.

Should SCDHHS initiate the Network Termination or Transition process, the CSO will be notified within twenty-four (24) hours of the decision by e-mail.

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

SCDHHS is responsible for creating, maintaining, and updating the project plan with input from the CSO. The CSO will be required to submit new networks, using the standard county network submission format. SCDHHS reserves the right to obtain copies of original Subcontracts (including PMPM rates, lists of services provided, applications, and approvals, and other information as requested in a format to be determined by SCDHHS). SCDHHS may, at its discretion, freeze (and reinstitute) the assignment of Medicaid MHN Members to the affected county(ies) at anytime. SCDHHS also reserves the right to allow Medicaid MHN Members to leave the affected plan in order to maintain Continuity of Care. Any additional cost incurred by the Enrollment broker or SCDHHS during this process will be reimbursed by the CSO.

3.5 Subcontractor Requirements

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

3.6 24-Hour Coverage Requirement

The contract between SCDHHS and the CSO requires PCPs in the MHN network provide access to medical advice and care for enrolled Medicaid MHN Members 24 hours per day, 7 days per week. There must be prompt (within one hour) access to a qualified medical practitioner who is able to provide medical advice, consultation, and authorization for services when appropriate. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

PCPs must provide Medicaid MHN Members with an after-hours telephone number. The after-hours telephone number must connect the Medicaid MHN Member to:

- An answering service that promptly contacts the PCP, or the PCP-authorized medical practitioner
- A recording that directs the caller to another number to reach the PCP, or the PCP-authorized medical practitioner
- A system that automatically transfers the call to a telephone line that is answered by a person who will promptly contact the PCP, or the PCP-authorized medical practitioner
- A call center system
- The PCP's home telephone number, if he/she so chooses

A hospital may be used for the 24-hour telephone coverage requirement under the following conditions:

- The 24-hour access line is not answered by the emergency department staff
- The PCP establishes a communication and reporting system with the hospital
- The PCP reviews results of all hospital-authorized services

An office telephone line that is not answered after hours, or answered with a recorded message instructing members to call back during office hours, or to go to the emergency department for care, is not acceptable. Additionally, it is not acceptable to

refer Medicaid MHN Members to a telephone number if there is no system in place, as outlined above, to respond to calls. PCPs are encouraged to refer Medicaid MHN Members with after-hours urgent medical problems to a non-hospital based urgent care center rather than the emergency room, provided there is one accessible.

3.7 Standards of Appointment Availability

PCPs must conform to the following standards for appointment availability:

- Emergency care – Immediately upon presentation or notification
- Urgent care – Within forty-eight (48) hours of presentation or notification
- Routine sick care – Within three (3) days of presentation or notification
- Routine well care – Within forty-five (45) days of presentation or notification (fifteen (15) days if pregnant)

3.8 Standards for Office Wait Times

PCPs must conform to the following standards for office wait times:

- Walk-ins – Within two (2) hours or schedule an appointment within the standards of appointment availability listed above
- Scheduled appointment – Within forty-five (45) minutes
- Life-threatening emergency – Must be managed immediately

3.9 Hospital Admitting Privileges Requirement

MHN PCPs must establish and maintain hospital admitting privileges for the management of inpatient hospital admissions of Medicaid MHN Members. This requirement must be met prior to the PCP providing medical services to Medicaid MHN Members.

If an MHN PCP does not have hospital admitting privileges, the CSO must have on file an attestation signed by the MHN PCP stating another physician, or group, will admit Medicaid MHN Members on the MHN PCP's behalf. The admitting physician/group must be enrolled in the South Carolina Medicaid program. The attestation must stipulate the admitting physician/group will provide medical/clinical documentation on the Medicaid MHN Member to the MHN PCP following discharge.

3.10 Medical Records

Medical records should reflect the quality of care received by the Medicaid MHN Member. In order to promote quality and Continuity of Care, MHN PCPS must adhere to

the guidelines as outlined in section one of the SCDHHS Physician Services provider manual.

3.11 Transfer of Medical Records

MHN PCPs must transfer the Medicaid MHN Member's medical record to the receiving Provider upon changing of the PCP, and as authorized by the Medicaid MHN Member within thirty (30) days of the date of the request at no charge to the Medicaid MHN Member.

4.0 QUALITY ASSESSMENT AND UTILIZATION MANAGEMENT REQUIREMENTS

All CSOs that contract with SCDHHS to provide Medicaid MHN Program Services must have a system for Quality Assessment (QA) and a Case Management program that meets the following standards:

1. Have a quality assessment system that:
 - a) Is consistent with applicable federal regulations
 - b) Provides for review by appropriate health professionals of the process followed in providing health services
 - c) Provides for systematic data collection of performance and patient results
 - d) Provides for interpretation of this data to the practitioners
 - e) Provides for making needed changes
2. Maintain and operate a QA program which includes at least the following elements:
 - a) Quality Assessment Program Description – A description of the QA program which outlines the CSO's mechanisms to monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems. The QA efforts should be health outcome oriented and rely upon data generated by the MHN/CSO as well as that developed by outside sources. The description must be organized and written so that staff members and practitioners can understand the program's goals, objectives and structure and should incorporate information from customer service, appeals and grievances, medical management, credentialing and provider relations. This description shall be submitted to SCDHHS annually.
 - b) QA Staff – The QA plan shall name a quality director, manager or coordinator responsible for the operation of the QA program. Such person shall be a health care professional (i.e., registered nurse, physician, CPHQ), who has the necessary knowledge and skills to design, implement, and maintain

ongoing health care quality, patient safety, utilization, and clinical risk management strategies, systems, processes, and associated activities. This person shall spend an adequate percentage of his/her time dedicated to QA activities to ensure the effectiveness of the QA program and be accountable for QA in all MHN providers and subcontractors. In addition, the medical director must have substantial regular involvement in QA activities.

- c) Annual Quality Assessment Work Plan – The work plan should include, but is not limited to, the planned activities, objectives, timeframes or milestones for each activity and the responsible staff member(s). This document should be submitted to SCDHHS annually and updated frequently to reflect the progress on all activities.
- d) Program Integrity Plan (SCDHHS Section 11.1)
- e) QA Committee – The CSO's QA program shall be directed by a QA committee which has substantial involvement of the medical director and includes membership from:
 - A variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.)
 - Participating network providers in a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.). The QA committee shall include OB/GYN and pediatric representation.
 - MHN management, Advisory Boards or Board of Directors
- f) The QA Committee shall be located within the MHN/CSO such that it is responsible for all aspects of the QA program.
- g) The QA Committee shall meet at least quarterly, produce dated and signed written documentation of all meetings and committee activities, and submit such documentation to appropriate entities within the MHN/CSO and SCDHHS.
- h) The QA activities of MHN providers and subcontractors, shall be integrated into the overall MHN/QA program. The MHN QA Program shall provide feedback to the providers/subcontractors regarding the integration of, operation of and corrective actions necessary in provider/subcontractor QA efforts. QA activities and results shall be reported in writing at least quarterly to the MHN, SCDHHS and its authorized agents.
- i) The MHN shall have a written procedure which addresses the MHN's approach to measurement, analysis, and interventions for QA activity findings. This procedure should include monitoring activities following intervention implementation. The measurement, analysis and interventions shall be documented in writing and submitted to appropriate entities with the CSO (i.e., QA Committee) and SCDHHS.
- j) The MHN/CSO shall make use of the SCDHHS utilization data which is supplied monthly.

- k) Quality Assessment and Performance Improvement Program (QAPI): The CSO shall have an ongoing quality assessment and performance improvement program for the services it furnishes to members. At a minimum, the CSO shall:
- Conduct performance improvement projects as described in this section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement. This improvement should be sustained over time, and have a favorable effect on both health outcomes and enrollee satisfaction.
 - Submit performance measurement data as described below.
 - Have in effect mechanisms to detect both under-utilization and over-utilization of services.
 - Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.
- l) Performance Measurements:
- Annually CSOs shall measure and report to SCDHHS its performance, using standard measures required by SCDHHS.
 - Submit to SCDHHS data specified by SCDHHS that enables SCDHHS to measure the performance
 - Perform a combination of the activities described in the items listed above
- m) Performance Improvement Projects (PIP): The CSO shall have an ongoing program of performance improvement projects (a minimum of two (2) projects) that focus on clinical and non-clinical areas, and involve the following:
- Measurements of performance using objective quality indicators
 - Implementation of system interventions to achieve improvement in quality
 - Evaluation of the effectiveness of the interventions
 - Planning and initiation of activities for increasing or sustaining improvement. The Contractor shall report the status and results of each project to SCDHHS, as requested.
 - Each performance improvement project must be completed in a reasonable and agreed-upon time period.
3. Submit information resulting from quality of care studies which includes care and services to be monitored in certain priority areas, as designated by SCDHHS. Such information shall include sufficient detail on purpose, scope, methods,

findings, and outcomes of such studies to enable the SCDHHS to understand the impact of the studies on the MHNs health care delivery system.

- At a minimum, required quality of care studies will include measures for prenatal care, newborn care, childhood immunizations, asthma, ER utilization and EPSDT examinations. Quality Measure Reports must be submitted to SCDHHS on a quarterly basis.
4. Assist the SCDHHS in its quality assurance activities.
 - a) The CSO will assist, SCDHHS and SCDHHS's External Quality Review Organization (EQRO) as needed in the identification of provider and beneficiary data required to carry out on-site medical chart reviews.
 - b) The CSO will arrange orientation meetings for physician office staff concerning on-site medical chart reviews.
 - c) The CSO will assist SCDHHS and the EQRO under contract with the SCDHHS, as needed, in securing records needed to conduct off-site medical chart reviews.
 - d) The CSO will facilitate training provided by SCDHHS to its providers.
 - e) The CSO will allow duly authorized agents or representatives of the State or Federal government access to CSO's premises or CSO subcontractor premises to inspect, audit, monitor or otherwise evaluate the performance of the CSOs or subcontractors contractual activities.
 5. Assure all persons, whether they are employees, agents, subcontractors or anyone acting for or on behalf of the provider, are properly licensed and/or certified under applicable state law and/or regulations, and are eligible to participate in the Medicaid/Medicare program (as required in the MHN Contract).
 - a) The CSO shall have policies and procedures for approval of new providers and termination or suspension of a provider.
 - b) The CSO shall have a mechanism for reporting quality deficiencies which result in suspension or termination of a provider.
 6. Have systems in place for coordination and continuation of care to ensure well managed patient care, including at a minimum:
 - a) Management and integration of health care through primary care providers
 - b) A referral system for medically necessary, specialty, secondary and tertiary care
 - c) Assurance of the provision of emergency care, including an education process to help assure members know where and how to obtain medically necessary care in emergency situations

7. The MHN/CSO shall have a system for maintaining medical records for all Medicaid members in the plan to ensure the record:
- a. Is accurate, legible and safeguarded against loss, destruction or unauthorized use and is maintained in an organized fashion for all individuals evaluated or treated, and is accessible for review and audit. The CSO shall maintain, or require its network providers and subcontractors to maintain individual medical records for each Medicaid member. Such records shall be readily available to SCDHHS and/or its designee and contain all information necessary for the medical management of each enrolled member. Procedures shall also exist to facilitate the prompt transfer of patient care records to other in - or out-of-plan providers.
 - b. Is readily available for MHN-wide QAI and CM activities and provides adequate medical and clinical data required for QA/CM.
 - c. Has adequate information and record transfer procedures to provide continuity of care, when members are treated by more than one provider.
 - d. Contain, at a minimum, the following items:
 - Patient name, Medicaid identification number, age, sex and places of residence and employment and responsible party (parent/guardian).
 - Services provided through the MHN, date of service, service site and name of service provider.
 - Medical history, diagnoses, prescribed treatment and/or therapy and drug(s) administered or dispensed. The medical record shall commence on the date of the first patient examination made through or by the MHN.
 - Referrals and results of specialist referrals.
 - Documentation of emergency and/or after-hours encounters and follow-up.
 - Signed and dated consent forms.
 - For pediatric records (**ages 12 and under**), record of immunization status.
 - Documentation of advance directive, if completed. The documentation for each visit must include:
 - Date
 - Purpose of visit
 - Diagnosis or medical impression
 - Objective finding
 - Assessment of patient's findings
 - Plan of treatment, diagnostic tests, therapies and other prescribed regimens
 - Medications prescribed

- o Health education provided
 - o Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.
8. The CSO must report EPSDT and other preventive visit compliance rates. For purposes of reporting individuals by age group, the individual's age should be their age on the date of service.
9. Have written case management policies and procedures which include, at a minimum:
- a) Protocols for:
 - 1. Prior approval of services
 - 2. Access to care coordination
 - 3. Access to disease management
 - 4. Hospital discharge planning
 - 5. Processes to identify utilization problems and corrective action
 - 6. An after-hours call log to practices and help line (or equivalent method) to track utilization and disposition;
 - b) An emergency room log (or equivalent method) to track emergency room utilization reports
10. Furnish members with approved written information regarding the nature and extent of their rights and responsibilities as a member of the MHN. The minimum information shall include:
- a) A description of the managed care plan and its physicians
 - b) Information about benefits and how to obtain them
 - c) Information on the confidentiality of patient information
 - d) Grievance and appeal rights
 - e) Eligibility and enrollment information
11. Maintain a grievance and appeal system which:
- a) Has written policies and procedures that are distributed to members. These policies and procedures must comply with 42 CFR 438.400-438.424.
 - b) Informs member they must exhaust the MHN grievance process prior to filing for a state fair hearing, and informs the member of the state fair hearing process and its procedures.

- c) Attempts to resolve grievances through internal mechanisms, whenever possible.
 - d) Maintains a record keeping system for oral and written grievances and records of disposition.
 - e) Provides to SCDHHS, on a quarterly basis, written summaries of the grievances which occurred during the reporting period to include:
 - Nature of grievance
 - Filing date
 - Current status
 - Resolutions
 - Any resulting corrective action
 - f) Upon request by SCDHHS or the MHN program member, the CSO shall forward any adverse decisions to SCDHHS for further review/action.
12. Allow for SCDHHS to evaluate each CSO's compliance with SCDHHS program policies and procedures; identify problem areas; and, monitor the CSO's progress in this effort. At a minimum this must include, but is not limited to, the following:
- a) SCDHHS review and approval of the CSO's written Quality Assurance and Improvement Plan. The CSO must submit any subsequent changes and/or revisions to its Quality Assurance and Improvement Plan to SCDHHS for approval on or before December 15th annually.
 - b) SCDHHS review and approval of the CSO's written grievance and appeal policies and procedures. Prior to implementation, the CSO must submit any subsequent changes and/or revisions to its Grievance and Appeal Policy and Procedures to SCDHHS for approval.
 - c) SCDHHS review of quality measure reports. The reports will be submitted to SCDHHS in the format specified by SCDHHS.
 - d) SCDHHS review of the CSO's reports of grievances, and resolution thereof.
 - e) SCDHHS approval of the CSO's Plan of Correction (POC) and monitoring of the disposition of identified items developed as a result of the annual external QA evaluation or any discrepancies found by SCDHHS that require corrective action.
13. External Quality Assurance Review. SCDHHS will provide for an independent review of services provided or arranged by the MHN/CSO. The review will be conducted annually by the External Quality Review Organization (EQRO) under contract with SCDHHS. External quality assurance evaluation and EQRO responsibilities shall include:

- a) Conducting an annual review of the Contractor. SCDHHS will convey the final report findings to the CSO, with a request for a POC, if one is warranted.
- b) Assisting the CSO in developing quality of care studies which meet SCDHHS quality indicators, in the event the CSO does not have sufficient resources or expertise to develop a focused quality of care study plan to conduct internal studies.
- c) Conducting workshops and trainings for CSO staff regarding the extraction of data for the quality of care studies and other features of the annual QA evaluation.
- d) SCDHHS will evaluate the CSO's compliance with QA standards through an annual comprehensive QA evaluation. The annual review shall consist of:
 1. **Quality of Care Studies:** A review of medical records by specific criteria which are selected by a statistically valid sampling methodology. The quality of care studies will focus on important aspects of patient care in the clinical settings. SCDHHS selected quality of care studies will require qualified surveyors to:
 - Collect aggregate data pertaining to the populations from which the sample medical records and administrative data will be selected. The quality of care studies will include indicators for prenatal care, newborns, childhood immunizations, asthma, ER utilization and EPSDT examinations. The EPSDT examinations must be broken down by age categories: under one (1) year, one (1) to five (5) years, six (6) to fourteen (14) years, and fifteen (15) to twenty (20) years.
 - Abstract data from selected medical records and claims data for childhood immunizations, prenatal care, newborns, asthma, ER utilization and EPSDT examinations.
 - The EQRO will compare findings of quality care studies with findings of the CSO's internal QA programs. The EQRO will also provide analysis and comparison of findings across all MHN's in the program and with findings from other state and national studies performed on similar populations.
 2. **Service Access Studies:** A review and evaluation of the MHN's/CSO's performance of availability and accessibility. Studies will focus on:
 - Emergency room service and utilization
 - Appointment availability and scheduling
 - Referrals
 - Follow-up care provided
 - Timeliness of services

3. **Medical Record Survey:** The CSO will describe the compliance with medical record uniformity of format, legibility, and documentation.
4. **Administrative Survey:** The CSO will be surveyed for administrative policies and procedures, committee structures, committee meeting minutes including governing body, executive, quality assurance and patient advisory. A review of the CSO's credentialing and recredentialing systems (if applicable) and professional contracts, support service contracts, personnel policies, performance evaluation examples, member education information, member grievance and appeal systems, member grievance files, and member disenrollment files.
5. **Exit Conference:** An exit conference will be held to discuss the QA evaluation findings.
6. **QA Evaluation Reports:** The EQRO will submit an individual draft report to SCDHHS 30 calendar days following the onsite visit and an individual MHN final report will be issued by SCDHHS. The results shall be available to participating health care providers, members and potential members. Final EQR results, upon request, must be made available in alternative formats for persons with sensory impairments and must be made available through electronic as well as printed copies. The report shall include, at a minimum, the following:
 - An assessment of the MHN's strengths and weaknesses
 - Recommendations for improving the quality of health care services furnished by the MHN
 - Comparative information about all MHNs operating within the state
 - An assessment of the degree to which the MHN has addressed effectively the quality improvement recommendations made during the previous year
7. Within thirty (30) calendar days (or as specified by SCDHHS) of receipt of the final QA evaluation report, the CSO must submit its Corrective Action Plan to SCDHHS, if deemed necessary by SCDHHS.
8. SCDHHS staff will conduct meetings with the CSO in order to monitor progress with the MHN's POC developed as a result of the annual QA evaluation. The meeting frequency shall be determined by SCDHHS, based on the findings of the annual QA evaluation.
9. If the CSO is accredited by an external organization (e.g., NCQA, URAC, etc.) the CSO shall provide SCDHHS with a copy of its accreditation review findings.

5.0 MEDICAID ELIGIBILITY

5.1 Medicaid Eligibility Determination

Individuals who meet financial and categorical requirements may qualify for South Carolina Healthy Connections (Medicaid).

The South Carolina Department of Health and Human Services determines eligibility for Medicaid. An individual applying for Medicaid as an SSI recipient must apply at the local Social Security office. Generally, an individual who is approved for SSI will automatically receive Medicaid. Applications for all other coverage groups may be filed in person or by mail. Applications may be filed at out-stationed locations such as the county health departments, federally qualified rural health centers, most hospitals and the county Department of Social Services. Applications may be mailed to:

South Carolina Department of Health and Human Services
Division of Central Eligibility Processing
PO Box 100101
Columbia, SC 29202-3101

Persons who are approved for Healthy Connections receive a permanent, plastic Healthy Connections card. They are instructed to take the card with them when they receive a medical service.

5.2 Infants and Medicaid Eligibility

Infants who are born to a Medicaid-Eligible pregnant woman are “deemed” to be eligible for Medicaid and continue to be eligible for Medicaid for one (1) year after delivery, as long as the child remains a resident of the state. Eligibility continues without regard to income. A separate Medicaid application is not required. Infants born to women eligible for Emergency Services only may not be deemed. A separate application and eligibility determination must be completed. SCDHHS cannot produce the infant’s Medicaid card without the child’s official name and correct date of birth.

“Non-deemed Infants” refers to infants who were not born to a Medicaid-Eligible woman. An application and eligibility determination must be completed for these infants. If an infant has siblings in the home who receive Medicaid under the Partners for Healthy Children or Low Income Families Program, the infant may be added to the case with the siblings. If the infant’s eligibility is determined under the Infants Program, the budget group consists of the infant and parents in the home and may also include the siblings, but only the infant is eligible. Once the infant is determined eligible, Medicaid benefits continue for one year regardless of changes in circumstances and the infant continues to meet non-financial criteria.

Should a child be hospitalized on his first birthday, Medicaid benefits continue until the last day of the month in which the hospital stay ended provided the following conditions are met:

- Eligibility would have ended because the child reached the maximum age for that category of assistance
- The child is otherwise eligible
- Inpatient hospital services were received on the day the child reached the maximum age

5.3 Annual Review – Medicaid Eligibility Redetermination

Sixty (60) days prior to the annual review date, the Beneficiary is sent a review form to complete. If the Beneficiary does not return the review form, the case is closed and eligibility is terminated.

If the Beneficiary returns an incomplete form, it is returned to the Beneficiary with a checklist identifying the missing information and instructions on how to correct the problem. If the missing information is not received by the next review date, the case is closed sixty (60) days after the original review form was mailed, usually on the next review date.

If the Beneficiary returns the form completed correctly, the date the form was received is entered in MEDS. The worker performs the review. Data from the review form is verified as necessary and a redetermination is made on the case. The case is either approved or closed.

If the Beneficiary returns the form after the case has been closed, the date the form was received will be compared to the closure date. If the received date is less than thirty (30) days after the closure date, the case is reopened and the review is processed as if it had been received on time.

If the Beneficiary returns the form more than thirty (30) days after the case has been closed, the review form is treated like a new application. If any additional verification is needed, a checklist is forwarded to the Beneficiary. The policy allows up to forty-five (45) days to make an eligibility determination on a new application. At this point, the case is either approved or denied.

For further information on eligibility or income and resource requirements, please see the SCDHHS Web site at www.scdhhs.gov

6.0 MANAGED CARE ENROLLMENT

Effective March 2011, CMS approved SCDHHS's request to expand managed care to require participation in an MCO or MHN for eligible beneficiary populations. For information on which beneficiary populations are now required to participate in managed care, see the Managed Care section within the agency's Web site – www.scdhhs.gov

All managed care enrollment, disenrollment and transfer requests are processed by SC Healthy Connections Choices (SCHCC). Information on the enrollment process, as well as plans and provider networks is located on the SC Choices Web site – www.SCchoices.com. Medicaid MHN Members shall be enrolled in a managed care plan for a period of twelve (12) months contingent upon their continued Medicaid eligibility.

Newly eligible Medicaid beneficiaries and beneficiaries going through the yearly eligibility re-determination process who also meet the criteria for Medicaid managed care participation will be informed of their various managed care choices. Before being assigned to a plan by SCHCC, Beneficiaries who are eligible for plan assignment are given at least thirty (30) days to choose an MCO/MHN. Beneficiaries not eligible for plan assignment may still enroll in a Managed Care Plan by calling SCHCC.

Existing Medicaid Beneficiaries may enroll with a managed care plan at any time. Once a person has joined or been assigned to a Managed Care Plan, they have ninety (90) days in which they may transfer to another plan without cause. This may only be done once during this period. After the ninety (90) day choice period has expired, Medicaid MHN Members must remain in their health plan until their one (1) year anniversary date, unless they have a special reason to make a change (See the Disenrollment section for details). CSOs may contact their Medicaid MHN Members to remind them of their upcoming anniversary date; however, follow-up must be within the guidelines in this manual.

A Medicaid MHN Member who loses and regains Medicaid eligibility within sixty (60) calendar days will be automatically re-enrolled into the same managed care plan. Depending on the date eligibility is regained; there may be a gap in the Beneficiary's enrollment into the MHN. If Medicaid eligibility is regained after sixty (60) calendar days, SCHCC will mail a new managed care enrollment packet to the Beneficiary.

6.1 MHN Enrollment Restrictions

The following Medicaid beneficiaries are not eligible to participate in a Medical Homes Network:

- Medically Complex Children's Waiver Program participants
- PACE participants
- Individuals institutionalized in a public facility
- Beneficiaries in a nursing home payment category (Residents of a nursing home)

- Participants in limited benefits programs such as Family Planning, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Beneficiaries covered by an HMO/MCO through third party coverage
- Beneficiaries enrolled in another Medicaid managed care program

6.2 Managed Care Enrollment of Newborns

Newborns of Medicaid MHN Members are not assigned to a managed care plan, but are placed in fee-for-service (FFS) for the first year of life unless the parent or legal guardian chooses a managed care plan, or the mother changes health plans during the first three (3) months following the Newborn's birth. A Newborn is defined as a Medicaid-Eligible Beneficiary who is under 365 days of age.

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

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

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

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

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

- If mother was enrolled in an MCO health plan in the birth month, the Newborn will be retroactively assigned to that health plan. The Newborn will remain in that health plan for the remainder of the year unless the mother changed MCO plans during the second or third month of the Newborn's life. In those cases, the Newborn will be transferred to the next MCO health plan for the remainder of their first year in managed care. If the mother transfers out of an MCO health plan (to an MHN or to fee-for-service Medicaid), the Newborn will not be transferred from the MCO's Plan.
- If mother was enrolled in an MHN health plan in the birth month, the newborn will NOT be assigned to that plan. If the mother had transferred to an MCO health plan in month's two or three of the newborn's life, the newborn will be assigned to that plan for the remainder of their first year in managed care.

- If the mother was not enrolled in any health plan during the first three months of the Newborn's life, the Newborn will receive an outreach Enrollment packet and the mother will have the option of selecting a health plan for the Newborn. This selection will begin on the first day of the next available assignment period after the choice is made.

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

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

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

7.0 MANAGED CARE DISENROLLMENT / TRANSFER

Disenrollments and transfers may be initiated by (1) the Medicaid MHN Member, (2) SCDHHS, or (3) the CSO. SCDHHS will notify the CSO of the Medicaid MHN Member's Disenrollment/transfer due to the following reasons:

- Loss of Medicaid Eligibility or loss of Medicaid MHN program Eligibility
- Death of the Member
- Member's intentional submission of fraudulent information
- Member becomes an Inmate of a Public Institution
- Member moves out of state
- Member becomes institutionalized in a Long-Term Care facility or nursing home for more than thirty (30) days
- Loss of Medicaid MHN participation
- Enrollment in a commercial HMO

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

7.1 Medicaid MHN Member-Initiated Disenrollment or Transfer

Following enrollment into a managed care plan, a Medicaid MHN Member may request to transfer or Disenroll once without cause during the ninety (90) days following the date of the member's initial Enrollment with the MHN. Disenrollment is limited only to those beneficiaries not in an eligibility category requiring participation in managed care. After the end of this ninety (90) day period, a Medicaid MHN Member shall remain in the MHN unless the Medicaid MHN Member:

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

A Medicaid MHN Member may request transfer or Disenrollment from the MHN as follows:

- For cause, at any time
- Without cause, at the following times:
 - During the ninety (90) days following the Medicaid MHN Member's initial Enrollment or re-Enrollment with the MHN
 - At least once every twelve (12) months thereafter

The following are considered cause for Disenrollment or transfer by the member:

- The Medicaid MHN Member moves out of the MHN's Service Area
- Other reasons, including but not limited to, poor Quality of care, lack of access to services covered under the contract, or lack of access to Providers experienced in dealing with the member's healthcare needs

Prior to approving the Medicaid MHN Member's Disenrollment or transfer request, SCDHHS will refer the request to the CSO to explore the Medicaid MHN Member's concerns and attempt resolution. The CSO must notify SCDHHS within ten (10) calendar days of the result of their intervention. The final decision on whether to allow the Medicaid MHN Member's Disenrollment or transfer rests with SCDHHS, not the

CSO. If a decision has not been reached within sixty (60) days, the Medicaid MHN Member's request to disenroll is automatically approved. Disenrollment is always effective the last day of the month, while enrollment is always effective the first of the following month.

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

7.2 CSO Initiated Disenrollment

A CSO's request for Medicaid MHN Member Disenrollment must be made in writing to South Carolina Healthy Connections Choices (SCHCC). The request must state, in detail, the reason for Disenrollment. SCHCC will log this request and forward it to SCDHHS for review.

SCDHHS will determine if the CSO has shown good cause to disenroll the Medicaid MHN Member and give written notification to the CSO and the Medicaid MHN Member of its decision. During this process, SCDHHS may request the CSO provide additional information and documentation. The CSO and the Medicaid MHN Member shall have the right to appeal any adverse decision.

The CSO shall immediately notify SCDHHS when it obtains knowledge of any Medicaid MHN Member whose Enrollment should be terminated prior to SCDHHS's knowledge. The CSO may request Disenrollment of a Medicaid MHN Member based upon the following reasons:

- CSO ceases participation in the Medicaid MHN program or in the Medicaid MHN Member's service area
- Member dies
- Member becomes an Inmate of a public institution
- Member moves out of state or MHN's service area
- Member becomes institutionalized in a Long-Term Care facility/nursing home for more than thirty (30) days
- Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the MHN's ability to furnish services to the member or other enrolled members
- Member is placed out of home (i.e., Intermediate Care Facility for the Mentally Retarded [ICF/MR], Psychiatric Residential Treatment Facility [PRTF]) 11

The CSO may not request Disenrollment because of an adverse change in the Medicaid MHN Member's health status, or because of the Medicaid MHN Member'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 CSO's ability to furnish services to either this, or other, Medicaid MHN Member(s)).

The same time frames that apply to Enrollment shall be used for changes in Enrollment and Disenrollment. If a Medicaid MHN Member's request to be disenrolled or change managed care plans is received and processed by SCDHHS by the monthly cut-off date, the disenrollment will be effective the last day of the month. If the Medicaid MHN Member's request is received and processed after the monthly cut-off date, the effective date of the change will be no later than the last day of the month following the month the Disenrollment request was approved.

8.0 PAYMENTS AND ADJUSTMENTS

8.1 MHN Shared Savings Formula Policy

CSOs receive a Per Member Per Month (PMPM) fee for each Medicaid MHN Member. This PMPM is for services rendered to Medicaid MHN Members as outlined in the MHN Contract with SCDHHS. In addition to the monthly PMPM, CSOs receive reimbursement for the realization of cost savings. The savings is determined by comparing the cost of Medicaid MHN Members against the cost of covering those members in a Medicaid MCO.

Using eligibility and enrollment data, each Network's enrollment is calculated and placed into age and sex cells developed for Medicaid MCO Member payment purposes, and then applied against the applicable MCO risk adjusted rates to develop the "Medicaid Upper Payment Limit". The "Medicaid Upper Payment Limit" is then compared against the claim expenditures of Medicaid MHN Members (including any prospective PMPM payments paid to the CSO) to determine whether the Network achieved savings. Claim expenditures incurred by Medicaid MHN Members include only those expenditures covered under the Medicaid MCO service package (including an adjustment for claims incurred but not reported).

If the Network realizes savings, SCDHHS reimburses the CSO 50% of the savings; however, payment cannot exceed five percent (5%) of the fee-for-service (FFS) payments incurred by the Network's enrollees. The CSO is responsible for dividing the savings between the participating practices and the CSO, as outlined in the contract between the CSO and its subcontractors. If the Network does not achieve savings, SCDHHS imposes a penalty on the CSO and a portion, if not all, of the PMPM must be refunded to SCDHHS. Only the PMPM payments are at risk since SCDHHS will continue to adjudicate claims to providers for services rendered on a FFS basis.

8.2 Sanctions

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

8.3 Per Member Per Month Payment Adjustment

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

8.4 Payment Responsibility for Hospital Stays When Enrollment/Disenrollment Occurs

The plan into which a Medicaid Beneficiary is enrolled on the day of admission to a hospital is responsible for the facility charges associated with the entire stay (through discharge), even if the Medicaid Beneficiary enrolls in a managed care plan during the hospital stay. The date of service will dictate the plan responsible for physician charges. If a Medicaid Beneficiary was enrolled in an MHN at the time of hospital admission, all claims for facility charges would be adjudicated by SCDHHS as claims for Medicaid MHN Members are reimbursed on a FFS basis.

For example, an MHN member is admitted to a hospital on August 20th and discharged on September 15th. On September 1, the member changes to an MCO. SCDHHS is responsible for all facility charges from admission (August 20th) to discharge since the member was enrolled in an MHN on the date of admission. Physician charges from August 20th to August 31st will be reimbursed by SCDHHS; however, the MCO will be responsible for physician charges from September 1st to discharge (September 15th).

9.0 GRIEVANCE AND APPEALS

Medicaid MHN Members have the right to appeal for the denial of services by requesting a state fair hearing. The appeal must be made to SCDHHS as SCDHHS is responsible for the authorization of services for Medicaid MHN Members. Complaints against MHN enrolled providers should be directed to the CSO, or to the SCDHHS Division of Care Management.

Should Medicaid MHN Members request a state fair hearing, they may, in writing, request that a provider represent them in the hearing. The provider cannot require the member appoint them as his or her representative as a condition of receiving service. The expectation is that the appointment will essentially coincide with the action giving rise to the appeal.

Pursuant to the CFR, the provider is not entitled to a state fair hearing. The member has that right and the provider may only represent the member if the member has requested a state fair hearing and has given the provider written consent to represent the member. The member drives the process because this grievance process is for the benefit of the member.

10.0 PRIOR AUTHORIZATIONS AND REFERRALS

PCPs are contractually required to provide medically necessary services, or issue a referral to another provider to evaluate and/or treat the Medicaid MHN Member. The referral is six (6) digits which may be numeric, alpha, or a combination of both. The issuance of a referral does not guarantee reimbursement as some services may require authorization to ensure medical necessity. The authorization for services is the responsibility of SCDHHS since claims are adjudicated on a FFS basis. Authorization must be obtained prior to rendering services. Failure to obtain prior authorization (PA) may result in non-payment of claims.

If a Medicaid MHN Member has failed to establish a medical record with the PCP, the CSO, in conjunction with the PCP, should arrange for the referral. The issuance of a referral is the responsibility of the PCP and CSO, not SCDHHS.

The CSO may centralize the referral process and is encouraged to design referral protocol to be implemented across all subcontractors. In some cases, a referral may be issued retroactively. The process for referring a member can be made verbally or in writing. The referral should include:

- The number of visits being authorized
- The extent of the diagnostic evaluation

Some services do not require referral. (*Refer to the list of exempt services in this section.*)

A referral is not required for services provided in a hospital emergency department, or for an admission to a hospital through the emergency department; however, the physician component for inpatient services does require a referral. The hospital should contact the PCP for a referral within forty-eight (48) hours of the Medicaid MHN Member's admission.

Specialist visits for follow-up care after hospital discharge also requires a referral from the PCP. If the specialist needs to refer the member to a second specialist for the same diagnosis, the Medicaid MHN Member's PCP must be contacted for a new referral. Should surgery be recommended, PCPs are required to issue a referral for a second opinion at the request of the Medicaid MHN Member.

Claims submitted for reimbursement must include the PCP's referral authorization number.

10.1 Referral Documentation

All referrals must be documented in the Medicaid MHN Member's medical record. The CSO and PCP should review the monthly referral data to ensure services rendered comply with the referral process. It is the PCP's responsibility to review the referral data and report inappropriate/unauthorized referrals to the CSO. The CSO is responsible for investigating inappropriate/unauthorized referrals and notifying SCDHHS should Medicaid fraud or abuse be suspected.

10.2 Services Not Requiring a Referral

Medicaid MHN Members may obtain the following services from Medicaid providers without first obtaining a referral from their PCPs:

- Ambulance
- Dentistry, Pedodontics, Oral Surgery (Dental only)
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services billed by the Hospital or EMTALA services billed by a hospital-based Urgent Care Clinic
- Family Planning Services
- Home and Community Based Waivers
- Independent Lab and X-ray¹
- Medical Transportation
- Nursing Home
- Obstetrics and Gynecology
- Optician
- Optometry
- Pharmacy
- Medicaid services provided by state agencies, including: Department of Mental Health, Continuum of Care, Department of Alcohol and Other Drug Abuse Services, Department of Disabilities and Special Needs, Department of Juvenile Justice, Department of Social Services.
- Speech and Hearing Clinic services

¹ FQHCs/RHCs that provide lab and x-ray services under a separate provider number (not the FQHC/RHC number), must enter a preauthorization number on the claim form or the claim will reject.

- Developmental Evaluation Center services
- BabyNet services
- Children's Rehabilitative services
- Sickle Cell Anemia services
- Early Intervention services

10.3 Medicaid MHN Member Billing

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

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

11.0 MEMBER BENEFITS

Medicaid MHN Member benefits mirror those offered to Medicaid fee-for-service beneficiaries as SCDHHS adjudicates all claims. The services and benefits are consistent with the outline and definition of covered services in the Title XIX SC State Medicaid Plan.

MHN plans are required to provide and coordinate Medicaid MHN Members "medically necessary" care, at the very least, at current limitations. Unless otherwise specified, service limitations are based on the State Fiscal Year (July 1 - June 30). More detailed information on Medicaid policy for services and benefits may be found in the corresponding Provider Manual. These manuals are available electronically on the SCDHHS Web site at www.scdhhs.gov.

MHN plans may offer additional services to Medicaid MHN Members. Additions, deletions or modifications to the additional services made during the contract year must be submitted to SCDHHS for approval at least thirty (30) days prior to implementation.

SCDHHS, on a regular basis, may expand, limit, modify or eliminate specific services, procedures and diagnosis codes offered by the South Carolina Medicaid program.

These changes may also affect maximum reimbursement rates and service limitations. Generally, these changes are documented and distributed via Medicaid bulletins.

12.0 MARKETING / ADVERTISING AND MEDICAID MHN MEMBER EDUCATION

All SCDHHS marketing/advertising and education Policies and procedures stated within this manual apply to staff, agents, officers, Subcontractors, volunteers and anyone acting for or on behalf of the CSO. Marketing/advertising/education is any communication that targets, or is interpreted by SCDHHS as having the intent to target existing or potential Provider and/or Medicaid MHN Members which are produced via any medium by, or on behalf of a CSO. Marketing/advertising/education materials include various formats of communication to include, but not limited to, brochures, pamphlets, books, videos, television and radio ads, and interactive electronic media to include social networks.

The CSO shall be responsible for developing and implementing a written Marketing/advertising/education plan designed to provide Medicaid MHN Members with information about the CSO's managed care plan. The CSO shall ensure all Medicaid managed care Marketing/advertising/ education Materials, brochures and presentations clearly present the core benefits and approved additional benefits, as well as any limitations.

The Marketing/advertising/ education plan and all related accompanying materials are governed by 42CFR § 438.104. A CSO should consult SCDHHS if additional guidance or interpretation is required prior to implementing a market plan or printing material. SCDHHS has the right to deny a CSO from issuing give-a-way items, printing materials, or participating in a marketing event.

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

- CSOs can, with SCDHHS written prior approval, utilize mass media which includes, but is not limited to, public service announcements such as radio and television spots (air time paid for by the CSO), advertising in newspapers, magazines, church bulletins, billboards and buses.
- All Marketing/advertising/education Materials/media (including Internet and social media sites, and items designed as “give-a-ways”) must include the SC Healthy Connections (SCHC) logo, the telephone number for Healthy Connections Choices (877-552-4642), and the plan's toll-free number. Current stock not containing the SCHC logo may be used until January 1, 2012; however, all stock ordered on or after February 3, 2011 must contain the SCHC logo.
- Educational Materials and third party publications, such as CDC guidelines, dietary information, Disease Management, etc. do not require the SCHC logo as

long as the CSOs name, logo and/or phone number are not present. If the CSO's logo and/or phone number is present, the SCHC logo must also be present. Current stock, not containing the SCHC logo may be used until September 1, 2011; however, all stock ordered on or after February 3, 2011 must contain the SCHC logo.

- All logos (SCHC and CSO) and associated phone numbers must be proportional in size and location.
- The CSO is allowed to offer nominal gifts with a fair market value of no more than \$10.00; with such gifts being offered regardless of the Beneficiary's intent to enroll in a plan. Cash gifts of any amount, including contributions made on behalf of people attending a Marketing event, gift certificates or gift cards are not permitted to be given to Medicaid MHN Members as incentives or rewards for healthy behaviors.
- The CSO may provide approved Marketing/advertising/give-a-ways/educational Materials for display and distribution by Subcontractors. This includes printed Material and audio/video presentations.
- CSOs can passively distribute approved Marketing/advertising/educational Materials, with written authorization from the entity responsible for the distribution site, to Medicaid Beneficiaries and Medicaid MHN Members. Passive distribution is defined as the display of Materials with no CSO Marketing or education staff present.
- CSOs may mail SCDHHS approved Marketing/advertising/educational Materials within its approved Service Areas. Mass mailings directed to only Medicaid Beneficiaries are prohibited.
- CSO's network Providers can correspond with Beneficiaries concerning their participation status in the Medicaid Program and the MHN. These letters may not contain CSO's Marketing/advertising/educational Materials or SCDHHS Enrollment forms. Letters must be developed, produced, mailed and/or distributed directly by the network Provider's office at their expense. This function cannot be delegated by the CSO, or an agent of the CSO. In addition, the use of these letters must be in accordance with the SC Department of Insurance Policies and regulations.
- The CSO is responsible for providing the Medicaid MHN Member with information on participating PCPs and assisting in determining if his or her current physician is a member of the MHN.
- Upon request by a Medicaid Beneficiary, Marketing representatives may provide him or her with information (excluding an Enrollment form) about the MHN to give to other interested Medicaid Beneficiaries (i.e., business card, Marketing brochure).
- The CSO shall ensure all Materials are accurate, are not misleading or confusing, and do not make material misrepresentations. Any claims stating the MHN is recommended or endorsed by any public or private agency or

organization, or by any individual must be prior approved by SCDHHS and must be certified in writing by the person or entity that is recommending or endorsing the MHN.

- All Materials shall be submitted for review and approval for readability, content, reading level, and clarity by SCDHHS or its designee, prior to use or distribution.
- The CSO shall ensure all written material will be written at a grade level no higher than the seventh (7) grade (7.9 or less on a reading scale such as Flesch or equivalent), or as determined appropriate by SCDHHS. An affidavit of reading level compliance must accompany each submission request for approval.
- The CSO shall ensure appropriate foreign language versions of all Marketing/advertising/education Materials are developed and available to Medicaid Beneficiaries and Medicaid MHN Members. Foreign language versions of Materials are required if the population speaking a particular foreign (non-English) language in a county is greater than ten (10) percent. If counties are later identified, SCDHHS will notify the CSO. These materials must be approved, in writing, by SCDHHS. Affidavits of accuracy and reading level compliance by a professional translation service must accompany all foreign language translations and be submitted with the approval request.
- When the CSO identifies Medicaid MHN Members who have visual and/or hearing impairments, an interpreter must be made available.
- The CSO's written Medicaid MHN Member material shall include its current network Provider list, which includes names, area of specialty, address (all location's address), and telephone number(s) of all participating Providers, groups and facilities including days of operations and hours of operations. It shall also include a map or description of the MHN's Service Area.
- The CSO's written material must include a definition of the terms "Emergency Medical Care" and "urgent medical care" and the procedures on how to obtain such care within and outside of the CSO's service area.
- The CSO must provide a description of its family planning services and services for communicable diseases such as TB, STD, and HIV/AIDS. Included must be a statement of the member's right to obtain family planning services from the plan or from any approved Medicaid enrolled provider. Also included must be a statement of the member's right to obtain TB, STD, HIV/AIDS services from any state public health agency.
- Summary documents and brochures must include a statement the document may contain only a brief summary of the plan and detailed information can be found in other documents, e.g. evidence of coverage, or obtained by contacting the plan.
- With written consent of the Subcontractor, the CSO is allowed to directly and/or indirectly conduct Marketing/advertising activities in a doctor's office, clinic, pharmacy, hospital or any other place where health care is delivered. This also includes government facilities, such as local offices of the SCDHHS, the

Department of Social Services, the Department of Health and Environmental Control, Head Start and public schools. The use of government facilities is only allowed with the written permission of the government entity involved. Any stipulations made by the Provider or government entity must be followed (allowable dates, times, locations, etc).

- All Marketing/advertising/education activities shall be conducted in an orderly, non-disruptive manner and shall not interfere with the privacy of Beneficiaries or the general community.
- The CSO may contact Medicaid MHN Members who are listed on their monthly Medicaid MHN Member listing to assist with Medicaid re-certification/eligibility.

12.1 Activities Which Are Not Permitted

- The CSO is prohibited from initiating direct contact (defined as face-to-face interaction) with a Beneficiary for the purposes of enrollment, or assisting a Beneficiary with enrolling into a health plan, distributing enrollment forms, or aiding a Medicaid Beneficiary with filling out or transmitting an Enrollment form.
- The CSO is not allowed to directly or indirectly conduct door-to-door, telephonic, or other “cold call” Marketing/advertising activities. This includes initiating contact with a Medicaid MHN Member of the public or Beneficiary at a Marketing event.
- The CSO shall not make any claims, or imply in any way, a Medicaid Beneficiary will lose his/her Medicaid benefits, or any other health or welfare benefits to which he or she is legally entitled, if he or she does not enroll with a managed care plan.
- The CSO cannot make offers of material or financial gain (such as gifts, gift certificates, insurance policies) to Medicaid Beneficiaries to induce plan Enrollment.
- The CSO shall not engage in Marketing/advertising practices, or distribute any Marketing/ advertising/education Materials that misrepresent, confuse or defraud Medicaid Beneficiaries, Providers or the public.
- The CSO cannot discriminate on the basis of a Medicaid MHN Member’s health status, prior health service use or need for present or future healthcare services. Discrimination includes, but is not limited to, expulsion or refusal to re-enroll as a Medicaid MHN Member except as permitted by Title XIX.
- The CSO’s Marketing representatives may not solicit or accept names of Medicaid Beneficiaries from Medicaid Beneficiaries or Medicaid MCO/MHN Members for the purpose of offering information regarding its plan.
- The CSO is prohibited from comparing their organization/plan to another organization/plan by name.
- The CSO may not market directly to Medicaid applicants/Beneficiaries through direct mail advertising or telemarketing.

- The CSO may not market directly market to a Beneficiary in his place of residence without first obtaining a signed statement from the Beneficiary giving permission for the CSO's representative to conduct a home visit for the sole purpose of Marketing activities.
- The CSO is not allowed to directly contact Disenrollees listed on their monthly Medicaid MHN Member listing.

12.2 Marketing Events and Activities

CSOs can conduct, sponsor and participate in marketing/advertising activities only with prior written notice to SCDHHS in a format defined by SCDHHS. Written approval by SCDHHS is NOT necessary. Notice of the date, time, details of what the CSO will be doing at the event and location of each activity/event must be received by noon (12 PM Eastern Time) by SCDHHS three (3) full business days prior to the event. South Carolina state holidays are excluded from being counted as a business day. (For example, if a marketing event is on Friday the 15th of the month, the notification to SCDHHS must be received by noon (12 PM) on Monday, the 11th. Using this same example, if Wednesday the 13th is a holiday, the notification must be received by noon (12 PM Eastern Time Friday the 8th). Any exceptions to this policy will be considered on a case-by-case basis.

When conducting marketing activities, the CSO may not initiate contact with members of the public or beneficiaries. They may respond to contact initiated by the member of the public or beneficiary. For example, if a marketing representative is operating a booth at a health fair – the representative may give out information or materials, if requested. The representative may not approach a person and give out information or material (including promotional items).

SCDHHS reserves the right to attend all marketing activities/events.

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

12.3 Focus Groups and Member Surveys

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

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

- Identity of the entity conducting the focus group event(s) or survey – CSO staff or name of the contractor
- Date, time, contact information and location of each event
- Selection criteria for participation
- Agenda/list of questions being asked to participants (The Division of Managed Care may require the CSO include certain questions in the survey or focus group.)
- List of all participant compensation in the form of case, gift cards, or prizes.

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

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

12.4 Member Services

The CSO shall maintain an organized, integrated member services function to assist MHN members in understanding the CSO's policies and procedures. The function of the member services unit is to provide additional information about the CSO's providers, facilitate referrals to providers and assist in the resolution of service and/or medical delivery concerns or problems. The CSO shall identify and educate its Medicaid MHN Members who access the system inappropriately and provide additional education, as needed. The CSO shall provide a written description of its Member services functions and handbook to its Members no later than fourteen (14) business days from receipt of enrollment data from SCDHHS.

12.5 Enrollment Incentives

No offers of material or financial gain, other than core benefits expressed in the CSO contract, may be made to any Medicaid Beneficiary as incentive to enroll or remain enrolled with the CSO. This includes, but is not limited to, cash, vouchers, gift certificates, insurance policies or other incentive. When marketing to current or potential Medicaid MHN Members, the CSO may only reference benefits or services clearly specified under the terms of their contract and available to Medicaid MHN Members for the full contract period. Additional benefits/Services which have been approved by SCDHHS may be included in marketing materials and events. These additional services/benefits include, but are not limited to: reduced or no copayments, additional services and visits over Medicaid limitations or membership in clubs and activities.

Violation of any of the listed Policies pertaining to marketing, advertising, and member education shall subject the CSO to sanctions, including suspension, fine and termination, as described in Section 13 of the MHN contract and as determined by the SCDHHS. The CSO may appeal these actions in writing to SCDHHS.

13.0 COORDINATION OF MANAGED CARE FRAUD AND ABUSE COMPLAINTS AND REFERRALS

The following set of Policies and procedures have been developed to govern the disposition of Fraud and abuse complaints along with the coordination of activities between SCDHHS and Managed Care Plans. Their purpose is to establish Policy for coordination and referral of complaints made against healthcare Providers providing services under a Managed Care Plan and Beneficiaries enrolled in a Managed Care Plan, in accordance with 42 CFR 455.

The Division of Program Integrity and the Division of Care Management will work jointly with the Managed Care Plans and Medical Home Networks providing services to the South Carolina Medicaid populations in order to ensure all complaints for Fraud and abuse are reviewed and investigated in a timely manner, and that Fraud referrals are made when appropriate. SCDHHS receives complaints via three main mechanisms: The Fraud hotline toll free number, 1-888-364-3224; the Fraud reporting fax line, (803) 255-8224; or the Program Integrity Extranet portal address.

A. Coordination Involving SCDHHS Fraud Hotline Complaints:

- If the SCDHHS Fraud Hotline receives a complaint about a Medicaid MHN Member's eligibility for Medicaid, the complaint is referred within three (3) business days to the Division of Program Integrity.
- If SCDHHS Fraud Hotline receives a complaint about a Medicaid MHN Member's utilization of benefits, the complaint is referred within three (3) business days to the appropriate Plan, using the SCDHHS secure portal to share information.
- If SCDHHS Fraud Hotline receives a complaint about a Provider with indications they are in a managed care network, the complaint is referred to Program Integrity and Division of Care Management for preliminary screening for Fraud and abuse and/or referral to the appropriate Plan for action.
- The Division of Program Integrity will capture data on complaints made against Medicaid MHN Members receiving services under a Managed Care Plan.

B. Coordination for Fraud and Abuse Complaints Received by Medical Homes Networks:

- If the CSO receives a complaint about a Medicaid MHN Member's eligibility for Medicaid, the complaint is referred to Program Integrity. The referral is made within three business days using the SCDHHS secure portal to share information.
- If the CSO receives a complaint about a Medicaid MHN Member's utilization of benefits, the complaint is handled internally in accordance with the Plan's Fraud and abuse/program integrity plan.

- If the CSO receives a complaint against a healthcare Provider or Subcontractor in its network, the CSO will investigate in accordance with its Fraud and abuse/program integrity plan.

C. Fraud and Abuse Referrals:

- If a complaint or the findings of a preliminary investigation give the CSO reason to believe that Fraud or abuse of the Medicaid Program has occurred, the CSO must immediately (within one (1) working day) report this information to the Division of Program Integrity. Any suspicion or knowledge of Fraud and abuse would include, but not be limited to, the false or fraudulent filings of claims and the acceptance or failure to return monies allowed or paid on claims known to be fraudulent, on the part of Medicaid MHN Member, employees, Providers, or Subcontractor. The CSO should submit all relevant information about the case, including its findings and the details of its investigation.
- Upon suspicion of Medicaid Fraud on the part of a Medicaid MHN Member, the CSO will refer the complaint to the Division of Program Integrity with all supporting evidence so the complaint can be referred to the Medicaid Recipient Fraud Unit in the SC Attorney General's Office. SCDHHS will refer the case to the Medicaid Recipient Fraud Unit either during its monthly meeting or as soon as possible in urgent cases
- Upon suspicion of Medicaid fraud on the part of a healthcare Provider paid to provide services to South Carolina Medicaid Beneficiaries, the Division of Program Integrity will refer the case to the Medicaid Fraud Control Unit in the SC Attorney General's Office, either during its monthly meeting or as soon as possible in urgent cases.
- Division of Care Management will send a copy to Program Integrity of any fraud and abuse reports received from the CSOs.
- For suspected Fraud cases against Providers and Medicaid MHN Members either initiated or referred by SCDHHS, SCDHHS will inform the CSO and the Division of Care Management when the case results in a criminal conviction, loss of benefits, and/or exclusion from the Medicaid Program.

D. Excluded Providers:

CSOs must check the Excluded Provider list prior to execution of a Provider contract at least annually.

E. Information Sharing:

The secure portal (extranet) established by Program Integrity should be used for sharing all Medicaid MHN Member and Provider information in the context of Fraud and abuse reviews and referrals. Each CSO has an assigned contact person and password. The portal address is: <https://extranet.scdhhs.gov/dhhs/Default.aspx?alias=extranet.scdhhs.gov/dhhs/pi>

14.0 INDEX OF REQUIRED FILES, REPORTS, AND FORMS

This chart is a summary listing of: 1) all files to be submitted by CSOs to SCHHHS, 2) all reports to be submitted by CSOs to SCDHHS and 3) all files to be submitted by SCDHHS to CSOs, and 4) all applicable SCDHS forms to be used by CSOs in the conduct of business. A file is defined as a set of related records compiled in a specified format. A report is defined as a written document containing predefined data elements or record of information and a form is defined as a document used to collect or report information. Copies of all file formats, reports, and forms can be found in the CSO Reports Companion Guide. The medium of all files and reports shall be electronic and follow the specifications noted in the Software Reporting Requirement of the 2010 MHN Contract **or** MMIS guidelines and requirements (as applicable).

All files/reports with a frequency of “monthly” are due no later than the 15th (fifteenth) day after the end of the reporting month. All files/reports with a quarterly frequency are due no later than the 30th (thirtieth) day after the end of the reporting quarter. All annual reports are due no later than the 90th (ninetieth) day after the end of the reporting year period. If the 15th (fifteenth), 30th (thirtieth), or 90th (ninetieth) day of the month falls on a weekend or state holiday, the reports will be due the last business day before the 15th (fifteenth), 30th (thirtieth), or 90th (ninetieth) day of the month in which the report is due.

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

GENERAL INSTRUCTIONS AND INFORMATION TECHNOLOGY REQUIREMENTS		
REPORT	FREQUENCY	RECIPIENT
Information Technology Standards for MHN		
Data Transmission Requirements		
Security Requirements For Users of SCDHHS's Computer Systems		
MHN Reports to SCDHHS	Frequency	Recipient
Network Providers and Subcontractors Listing Spreadsheet Requirements	Monthly	Department of Managed Care, Quality Programs
After-Hours Calls Log (Practices and Help Line)	Quarterly	Department of Managed Care, Quality Programs
New Member Contact Log	Quarterly	Department of Managed Care, Quality Programs
Grievance Log with Summary Information	Collected Monthly and Reported Quarterly	Department of Managed Care Nurse Administrator for Quality
Appeals Log with Summary Information	Collected Monthly and Reported Quarterly	Department of Managed Care, Quality Programs

Medical Homes Network Policy and Procedure Guide

GENERAL INSTRUCTIONS AND INFORMATION TECHNOLOGY REQUIREMENTS		
REPORT	FREQUENCY	RECIPIENT
Medically Complex Children's Waiver Documentation of Services included in the Enhanced Primary Care Rates - Documentation Format	Reported Monthly	MCC program staff
Case Management Plan	Annually	Department of Managed Care, Quality Programs
Quality Assurance (QA): A. QA Plan B. QA Plan of Correction C. Quality Indicators D. Reporting Measures	As Required As Required Quarterly Annually	Department of Managed Care, Quality Programs
Member Satisfaction Survey	Annually	Department of Managed Care, Quality Programs
Performance Standards – PCP Compliance with After-Hours Coverage Standards	Annually	Department of Managed Care Quality Programs
Performance Standards – PCP Compliance with Appointment Availability Standards	Annually	Department of Managed Care, Quality Programs
Performance Standards – PCP Compliance with Office Visit Times Standards	Annually	Department of Managed Care, Quality Programs
SCDHHS FILES TO MHNS	Frequency	Recipient
Managed Care MLE Record Description	Monthly	MHN
Claims Record Description	Monthly	MHN
MHN Recipient Record Layout	Monthly	MHN
MCO/MHN Recipient Review Recertification File	Monthly	MHN
MHN Record Description Reference File	Monthly	MHN
MCO/MHN/MAXIMUS Sync File Layout	At least monthly	MHN
APPENDICES		
County Listing		
Provider Practice Specialty Table		
Bills of Rights		
FORMS LISTING		
Plan Initiated Disenrollment Request Form SCDHHS Request for Medicaid ID Number Form (SCDHHS 1716 ME) WIC Referral Form Medical Release Form MHN Hospital Admission Agreement/Formal Arrangement MHN Complaint Form		

15.0 DEFINITION OF TERMS

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

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

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

Additional Services – Services provided by health plans (MCO and MHN) which are non-covered by the SCDHHS under the South Carolina State Plan for Medical Assistance.

Applicant – An individual seeking Medicaid eligibility through written application.

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

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

CFR – Code of Federal Regulations.

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

CMS – Centers for Medicare and Medicaid Services

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

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

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

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

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

CPT – Current Procedural Terminology, most current edition.

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

DHEC – South Carolina Department of Health and Environmental Control.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HCPCS – CMS's Common Procedure Coding System.

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

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

HHS – United States Department of Health and Human Services.

ICD – International Classification of Disease, Clinical Modification,

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

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

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

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

Marketing – Any form of communication (telephonic, web based, social network and other determined by SCDHHS) must be approved by SCDHHS from an CSO to an existing or potential Medicaid Recipient that can be interpreted as intended to influence the Recipient to enroll in that particular CSO Medicaid product, or either to not enroll, or to disenroll from, another CSO Medicaid product.

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

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

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

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

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

Medical Record – A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, including, but not limited to, outpatient and emergency medical health care.

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

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

MMIS – Medicaid Management Information System.

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

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

NDC – National Drug Code.

Newborn – A live child born to a member.

Non-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 CSO to provide health care services.

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

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

Ownership Interest – The possession of equity in the capital, the stock or the profits of the entity, and must be disclosure to SCDHHS on the Disclosure Form found on SCDHHS Web site. For further definition see 42 CFR 455.101 (2009 as amended).

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

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

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

Primary Care Provider (PCP) – The provider who serves as the entry point into the health care system for the Medicaid MHN Member. The PCP is a medical doctor, who has agreed to be responsible for providing Primary Care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining Continuity of Care.

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

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

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

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

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

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

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

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

SCDHHS – South Carolina Department of Health and Human Services

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

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

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

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

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

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

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 MHN Member.

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

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

APPENDICES

APPENDIX 1 — COUNTY LISTING

- | | |
|-------------------------|--|
| 01. Abbeville | 28. Kershaw |
| 02. Aiken | 29. Lancaster |
| 03. Allendale | 30. Laurens |
| 04. Anderson | 31. Lee |
| 05. Bamberg | 32. Lexington |
| 06. Barnwell | 33. McCormick |
| 07. Beaufort | 34. Marion |
| 08. Berkeley | 35. Marlboro |
| 09. Calhoun | 36. Newberry |
| 10. Charleston | 37. Oconee |
| 11. Cherokee | 38. Orangeburg |
| 12. Chester | 39. Pickens |
| 13. Chesterfield | 40. Richland |
| 14. Clarendon | 41. Saluda |
| 15. Colleton | 42. Spartanburg |
| 16. Darlington | 43. Sumter |
| 17. Dillon | 44. Union |
| 18. Dorchester | 45. Williamsburg |
| 19. Edgefield | 46. York |
| 20. Fairfield | 60. Georgia within SC service area |
| 21. Florence | 61. Georgia outside SC service area |
| 22. Georgetown | 62. North Carolina within SC service area |
| 23. Greenville | 63. North Carolina outside SC service area |
| 24. Greenwood | 64. Other |
| 25. Hampton | |
| 26. Horry | |
| 27. Jasper | |

APPENDIX 2 — MEMBERS' AND POTENTIAL MEMBERS' BILL OF RIGHTS

Each Member is guaranteed the following rights:

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

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

APPENDIX 3 — PROVIDERS' BILL OF RIGHTS

Each Health Care Provider who contracts with SCDHHS and with the local Medical Homes Network to furnish services to the members shall be assured of the following rights:

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

APPENDIX 4 — TRANSPORTATION BROKER LISTING AND CONTACT INFORMATION

<u>Broker: LogistiCare</u>	<u>Broker: Access2Care</u>	<u>Broker: Access2Care</u>
<p>If you live in one of these counties call: 1-866-910-7688</p> <p>Region 1</p> <p>Abbeville Anderson Cherokee Edgefield Greenville Greenwood Laurens McCormick Oconee Pickens Saluda Spartanburg</p>	<p>If you live in one of these counties call: 1-855-777-1255</p> <p>Region 2</p> <p>Aiken Allendale Bamberg Barnwell Calhoun Chester Clarendon Fairfield Kershaw Lancaster Lee Lexington Newberry Orangeburg Richland Sumter Union York</p>	<p>If you live in one of these counties call: 1-855-777-1255</p> <p>Region 3</p> <p>Beaufort Berkeley Charleston Chesterfield Colleton Darlington Dillon Dorchester Florence Georgetown Hampton Horry Jasper Marion Marlboro Williamsburg</p>