

**CONTRACT**

**BETWEEN**

**SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**AND**

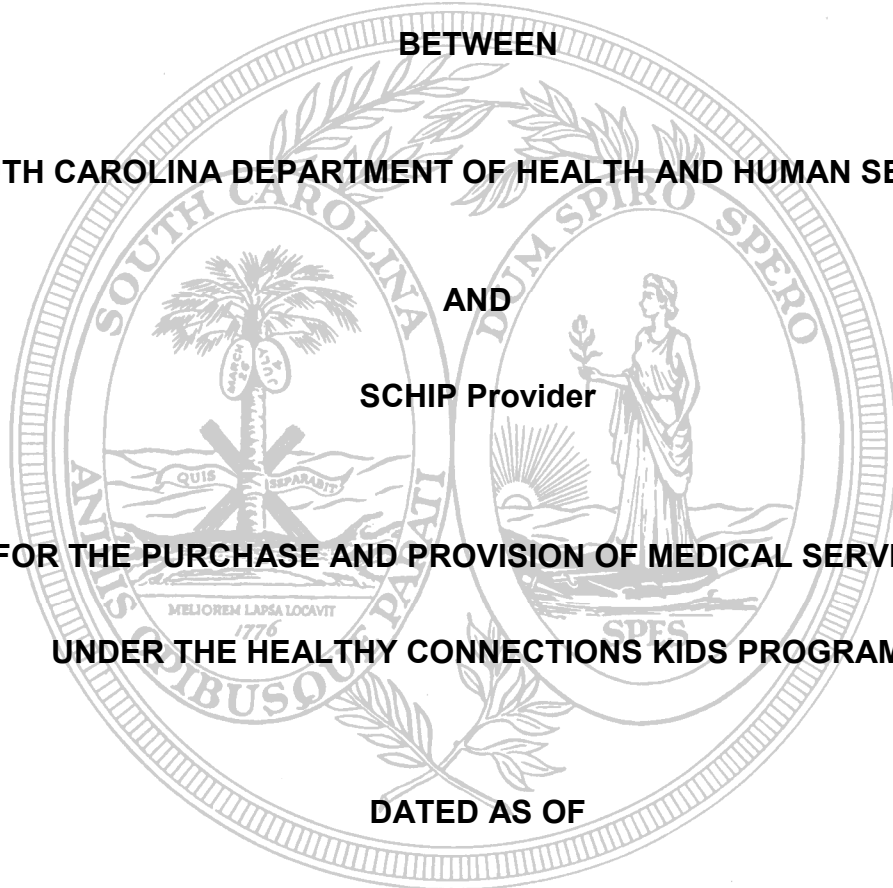
**SCHIP Provider**

**FOR THE PURCHASE AND PROVISION OF MEDICAL SERVICES**

**UNDER THE HEALTHY CONNECTIONS KIDS PROGRAM**

**DATED AS OF**

**APRIL 1, 2010**



# TABLE OF CONTENTS

<b>RECITALS</b> .....	1
<b>1 GENERAL PROVISIONS</b> .....	2
1.1 <u>Effective Date and Term</u> .....	2
1.2 <u>Notices</u> .....	2
1.3 <u>Definitions</u> .....	3
1.4 <u>Entire Agreement</u> .....	3
1.5 <u>Federal Approval of Contract</u> .....	3
1.6 <u>Extension and Renegotiation</u> .....	3
1.7 <u>Amendments</u> .....	4
<b>2 FINANCIAL MANAGEMENT</b> .....	4
2.1 <u>Capitation Payments</u> .....	4
2.2 <u>Payment to Federally-Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Teaching Hospitals</u> .....	4
2.3 <u>Co-payments</u> .....	5
2.4 <u>Ancillary Services</u> .....	5
2.5 <u>Return of Funds</u> .....	5
2.6 <u>Third Party Liability</u> .....	5
2.7 <u>Fidelity Bonds</u> .....	6
2.8 <u>Stop Loss</u> .....	6
2.9 <u>Protection Against Insolvency</u> .....	6
2.10 <u>Surplus Start Up Account</u> .....	6
2.11 <u>Surplus Account Reserves</u> .....	6
2.12 <u>Insurance</u> .....	6
2.13 <u>Proof of Insurance</u> .....	7
2.14 <u>Reinsurance</u> .....	7
2.15 <u>Errors and Omissions Insurance</u> .....	7
<b>3 CONTRACTOR'S PLAN ADMINISTRATION AND MANAGEMENT</b> .....	7
3.1 <u>Health Plan Administration and Management</u> .....	7
3.2 <u>Credentialing and Recredentialing of Staff</u> .....	10
3.3 <u>Training</u> .....	10
3.4 <u>Liaisons</u> .....	10
3.5 <u>Material Changes</u> .....	11
3.6 <u>Integrity of Professional Advice to Enrollees</u> .....	11
3.7 <u>Notification of Legal Action</u> .....	11
3.8 <u>Fraud and Abuse Compliance/Program Integrity Plan</u> .....	11
3.9 <u>Ownership</u> .....	12
3.10 <u>Excluded Parties</u> .....	12
<b>4 SERVICES</b> .....	13
4.1 <u>Core Benefits for the South Carolina SCHIP Program</u> .....	13
4.2 <u>Well Child Visits</u> .....	14
4.3 <u>Emergency Medical Services</u> .....	15
4.4 <u>Limitations of Abortions</u> .....	16
4.5 <u>Medical Services for Special Populations</u> .....	16
4.6 <u>Excluded Services</u> .....	17
4.7 <u>Expanded Services/Benefits</u> .....	17
4.8 <u>Care Coordination</u> .....	17

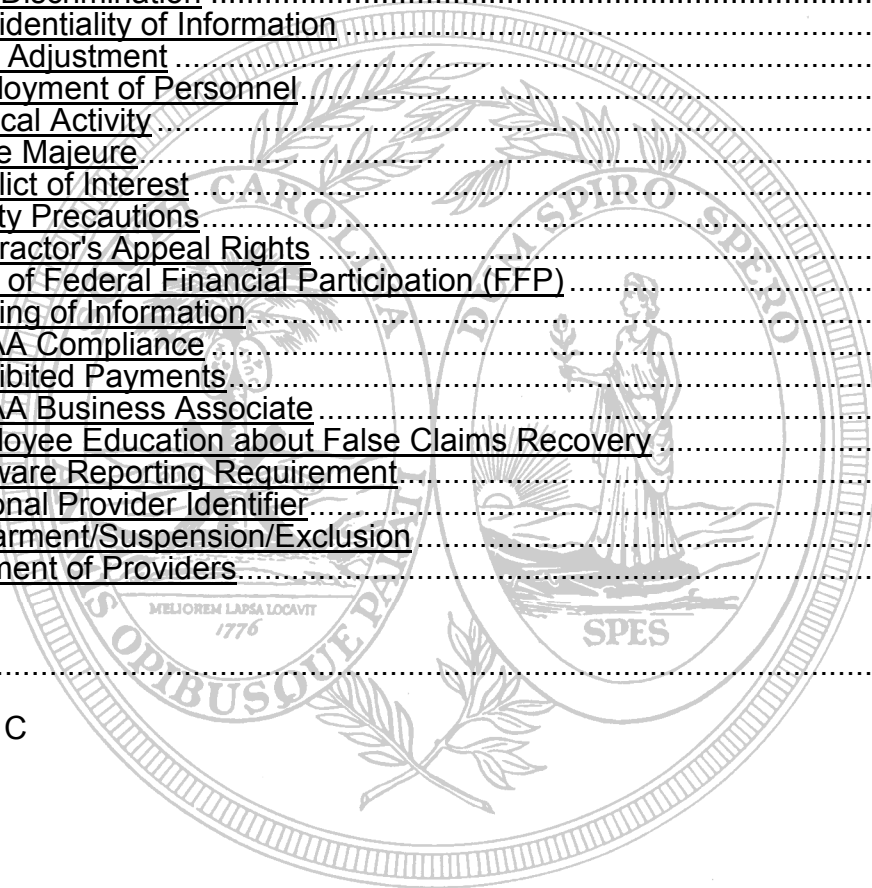
4.9	<u>Manner of Service Delivery and Provision</u>	20
4.10	<u>Service Accessibility Standards</u>	24
4.11	<u>Authorization and Referral System</u>	26
4.12	<u>Cultural Considerations</u>	26
4.13	<u>Prior Authorization</u>	26
<b>5</b>	<b>SUBCONTRACTS</b>	<b>27</b>
5.1	<u>Subcontract Requirements</u>	27
<b>6</b>	<b>EDUCATION, SELECTION AND ENROLLMENT PROCESS</b>	<b>33</b>
6.1	<u>Enrolling Eligibles in the Contractor's Plan</u>	33
6.2	<u>Enrollment Period</u>	33
6.3	<u>Selection or Assignment of a PCP</u>	34
6.4	<u>Newborns</u>	34
6.5	<u>Contractor Follow Up of Voluntary Disenrollees</u>	34
6.6	<u>Member Initiated Disenrollment and Change of Managed Care Plans</u>	34
6.7	<u>Contractor Initiated Member Disenrollment of Participation</u>	35
6.8	<u>SCDHHS Initiated Member Disenrollment</u>	36
6.9	<u>Notification to Managed Care Plan of Membership</u>	37
6.10	<u>Toll Free Telephone Number</u>	37
6.11	<u>Tracking Slot Availability</u>	37
6.12	<u>Billing and Reconciliation</u>	38
<b>7</b>	<b>MARKETING</b>	<b>38</b>
7.1	<u>Information Provided to Enrollees</u>	38
7.2	<u>Marketing Plan and Materials</u>	39
7.3	<u>Approval of Marketing Plan and Materials</u>	39
<b>8</b>	<b>POST ENROLLMENT PROCESS</b>	<b>40</b>
8.1	<u>Member Identification Card</u>	40
8.2	<u>Member Services Availability</u>	40
8.3	<u>Member Education</u>	40
8.4	<u>Member's Rights and Responsibilities</u>	41
<b>9</b>	<b>Grievance and Appeal Procedures</b>	<b>42</b>
9.1	<u>Definitions</u>	42
9.2	<u>General Requirements</u>	42
9.3	<u>Notice of Grievance and Appeal Procedures</u>	43
9.4	<u>Grievance/Appeal Records and Reports</u>	43
9.5	<u>Handling of Grievances and Appeals</u>	44
9.6	<u>Notice of Action</u>	45
9.7	<u>Resolution and Notification</u>	47
9.8	<u>Expedited Resolution of Appeals</u>	49
9.9	<u>Continuation of Benefits While the Contractor Level Appeals and the State Fair Hearing are Pending</u>	49
9.10	<u>Grievance System Information</u>	51
9.11	<u>Recordkeeping and Reporting Requirements</u>	51
9.12	<u>Effectuation of Reversed Appeal Resolutions</u>	51
<b>10</b>	<b>REPORTING REQUIREMENTS</b>	<b>51</b>
10.1	<u>Contractor's Network Providers and Subcontractors</u>	52

10.2	<u>Individual Encounter/Claim Data</u>	52
10.3	<u>Abortion Reporting</u>	53
10.4	<u>Grievance/Appeal Log Summary Reporting</u>	53
10.5	<u>Institutional Long Term Care/Nursing Home Reporting</u>	53
10.6	<u>Disenrollment Reporting</u>	53
10.7	<u>Quality Assessment and Performance Improvement</u>	53
10.8	<u>Member Satisfaction Survey</u>	54
10.9	<u>Additional Reports</u>	54
10.10	<u>Ownership Disclosure</u>	54
10.11	<u>Information Related to Business Transactions</u>	54
10.12	<u>Information on Persons Convicted of Crimes</u>	55
10.13	<u>Errors</u>	55
10.14	<u>Coding Requirements</u>	55
<b>11</b>	<b>QUALITY ASSESSMENT, MONITORING AND REPORTING</b>	56
11.1	<u>Quality, Assessment and Performance Improvement</u>	56
11.2	<u>Inspection, Evaluation and Audit of Records</u>	57
11.3	<u>Changes Resulting from Monitoring and Audit</u>	58
11.4	<u>Medical Records Requirements</u>	59
11.5	<u>Record Retention</u>	59
11.6	<u>Program Integrity</u>	59
<b>12</b>	<b>SCDHHS RESPONSIBILITIES</b>	60
12.1	<u>SCDHHS Contract Management</u>	60
12.2	<u>Payment of Capitated Rate</u>	60
12.3	<u>Required Submissions</u>	60
12.4	<u>Immunization Data</u>	60
12.5	<u>Notification of SCHIP Program Policies and Procedures</u>	60
12.6	<u>Provider Participation</u>	61
12.7	<u>Quality Assessment and Monitoring Activities</u>	61
12.8	<u>Marketing</u>	62
12.9	<u>Grievance/Appeals</u>	62
12.10	<u>Training</u>	62
12.11	<u>Federal Fund Restrictions</u>	62
<b>13</b>	<b>TERMS AND CONDITIONS</b>	62
13.1	<u>Applicable Laws and Regulations</u>	63
13.2	<u>Termination</u>	64
13.3	<u>Liquidated Damages for Failure to Meet Contract Requirements</u>	71
13.4	<u>Use of Data</u>	73
13.5	<u>Sanctions</u>	73
13.6	<u>Non-Renewal</u>	75
13.7	<u>Plan of Correction Required (Contract Non-Compliance)</u>	75
13.8	<u>Inspection of Records</u>	76
13.9	<u>Non-Waiver of Breach</u>	76
13.10	<u>Non-Assignability</u>	76
13.11	<u>Legal Services</u>	76
13.12	<u>Attorney's Fees</u>	77
13.13	<u>Independent Contractor</u>	77
13.14	<u>Governing Law and Place of Suit</u>	77
13.15	<u>Severability</u>	77
13.16	<u>Copyrights</u>	77
13.17	<u>Subsequent Conditions</u>	78

13.18	<u>Incorporation of Schedules/Appendices</u> .....	78
13.19	<u>Titles</u> .....	78
13.20	<u>Safeguarding Information</u> .....	78
13.21	<u>Release of Records</u> .....	78
13.22	<u>Fraudulent Activity</u> .....	79
13.23	<u>Fraud Abuse and Compliance Plan</u> .....	79
13.24	<u>Integration</u> .....	79
13.25	<u>Hold Harmless</u> .....	80
13.26	<u>Hold Harmless as to the SCHIP Program Members</u> .....	81
13.27	<u>Non-Discrimination</u> .....	81
13.28	<u>Confidentiality of Information</u> .....	81
13.29	<u>Rate Adjustment</u> .....	82
13.30	<u>Employment of Personnel</u> .....	82
13.31	<u>Political Activity</u> .....	82
13.32	<u>Force Majeure</u> .....	83
13.33	<u>Conflict of Interest</u> .....	83
13.34	<u>Safety Precautions</u> .....	83
13.35	<u>Contractor's Appeal Rights</u> .....	83
13.36	<u>Loss of Federal Financial Participation (FFP)</u> .....	84
13.37	<u>Sharing of Information</u> .....	84
13.38	<u>HIPAA Compliance</u> .....	84
13.39	<u>Prohibited Payments</u> .....	84
13.40	<u>HIPAA Business Associate</u> .....	84
13.41	<u>Employee Education about False Claims Recovery</u> .....	85
13.42	<u>Software Reporting Requirement</u> .....	85
13.43	<u>National Provider Identifier</u> .....	85
13.44	<u>Debarment/Suspension/Exclusion</u> .....	85
13.45	<u>Payment of Providers</u> .....	86

TESTIMONIUM.....	87
------------------	----

APPENDICES A - C	
------------------	--



**CONTRACT BETWEEN THE SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES AND SCHIP PROVIDER FOR THE PURCHASE AND PROVISION OF MEDICAL SERVICES UNDER THE SOUTH CAROLINA HEALTHY CONNECTIONS KIDS PROGRAM DATED AS OF APRIL 1, 2010**

This Contract is entered into as of the first day of April 2010, by and between the South Carolina Department of Health and Human Services, Post Office Box 8206, 1801 Main Street, Columbia, South Carolina, 29202-8206, hereinafter referred to as "SCDHHS" and SCHIP PROVIDER hereinafter referred to as "Contractor".

**RECITALS**

WHEREAS, SDHHS is the single state agency responsible for the administration of the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act and makes all final decisions and determinations regarding the administration of the Medicaid program.

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

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

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

WHEREAS, the Contractor is engaged in said business and is willing to provide such health care services to SCHIP MCO Program members upon and subject to the terms and conditions stated herein, and in accordance with 42 CFR Part 457 et seq.

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

# 1 GENERAL PROVISIONS

## 1.1 Effective Date and Term

This Contract and its appendices, hereby incorporated, contain all of the terms and conditions agreed upon by the parties. This Contract shall be effective no earlier than the date it has been signed by the Contractor and SCDHHS, and shall continue in full force and effect from April 1, 2010 until March 31, 2012 unless terminated prior to that date by provisions of this Contract. The documents referenced in this Contract are on file with the Contractor and with SCDHHS, and the Contractor is aware of their content.

## 1.2 Notices

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

In case of notice to Contractor:  
SCHIP Provider  
1234 Main Street, Suite 123  
Columbia, South Carolina 29201

In case of notice to SCDHHS:

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

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

Said notices shall become effective on the date specified within the notice. Either party may change its address for notification purposes by mailing a notice stating the change, effective date of the change and setting forth the new address. If different representatives are designated after execution of this Contract, notice of the new representative will be rendered in writing to the other party and attached to originals of this Contract.

### 1.3 Definitions

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

### 1.4 Entire Agreement

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

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

### 1.5 Federal Approval of Contract

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

### 1.6 Extension and Renegotiation

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



## 1.7 Amendments

This Contract may be amended at anytime as provided in this paragraph. This Contract shall be amended whenever required by changes in state and/or federal law or regulations. No modification or change of any provision of the Contract shall be made or construed to have been made unless such modification is mutually agreed to in writing by the Contractor and SCDHHS, and incorporated as a written amendment to this Contract prior to the effective date of such modification or change.

## 2 **FINANCIAL MANAGEMENT**

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

### 2.1 Capitation Payments

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

SCDHHS reserves the right to defer remittance of the capitation payment for July until on or after the first day of July to comply with state fiscal policies and procedures.

### 2.2 Payment to Federally-Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Teaching Hospitals

The capitation payment to the Contractor includes the units and expenditures applicable to the FQHCs and RHCs. No adjustments were made to the claims data to make FQHC and RHC payment levels equivalent to fee for service payment levels. Therefore, supplemental payments will not be performed by the state for FQHC and RHC services provided to individuals eligible under this SCHIP separate contract.

The capitation payment to the Contractor includes the inpatient claims and inpatient expenditures applicable to both teaching and non-teaching hospitals. No adjustments were made to the claims data to exclude Graduate Medical Education (GME) expenditures from the claim payments. This would include both Direct Medical Education (DME) and Indirect Medical Education (IME) expenditures. Therefore, supplemental payments will not be performed by the state for inpatient hospital services provided by teaching hospitals to individuals eligible under this SCHIP separate program.

### 2.3 Co-payments

No Co-payments are allowed.

### 2.4 Ancillary Services

Ancillary services, which are provided in the hospital include, but are not limited to, radiology, pathology, emergency medicine and anesthesiology. When the Contractor's member is provided these services (either inpatient or outpatient) the Contractor shall reimburse the professional component of these services at the Medicaid fee-for-service rate, unless another reimbursement rate has been previously negotiated. Prior authorization for these services shall not be required of either network or non-participating providers.

### 2.5 Return of Funds

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

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

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

### 2.6 Third Party Liability

A child who has creditable health coverage is not eligible for the SCHIP separate program. Creditable health coverage is defined as coverage with, at a minimum, hospitalization, doctor visits, x-ray and lab coverage. If the child's coverage does not have this basic coverage, he/she can qualify for SCHIP. The MCO must report to SCDHHS if it learns that the SCHIP member has creditable health coverage.

## 2.7 Fidelity Bonds

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

## 2.8 Stop Loss

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

## 2.9 Protection Against Insolvency

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

## 2.10 Surplus Start Up Account

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

## 2.11 Surplus Account Reserves

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

## 2.12 Insurance

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

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

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

#### 2.13 Proof of Insurance

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

#### 2.14 Reinsurance

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

#### 2.15 Errors and Omissions Insurance

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

### **3 CONTRACTOR'S PLAN ADMINISTRATION AND MANAGEMENT**

#### 3.1 Health Plan Administration and Management

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

The Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse in accordance with 42 CFR §457.955.

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

### 3.1.1 Staff Requirements

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

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

### 3.1.2 Licensure of Staff

All of the Contractor's network providers must be licensed and/or certified by the appropriate South Carolina licensing body or standard-setting agency, as applicable. All of the Contractor's network providers/subcontractors must be eligible to participate in the SCHIP as stated in 42 CFR Part 457 et seq. and must comply with all applicable statutory and regulatory requirements of the program.

The Contractor shall be responsible for assuring that all persons, whether employees, agents, subcontractors or anyone acting for or on behalf of the Contractor, are properly licensed at all times under applicable state law and/or regulations and are not barred from participation in the Medicaid and/or Medicare program. All health professionals and health care facilities used in the delivery of services by or through the Contractor shall be currently licensed to practice or operate in the state as defined and required by this Contract and the standards specified in the **Policy and Procedure Guide**, Provider Certification and Licensing. The Contractor shall ensure that none of its subcontractors have a Medicaid Contract with SCDHHS that was terminated, suspended, denied, or not renewed as a result of any action of the CMS of the U.S. Department of Health and Human Services or the Medicaid Fraud Control Unit of the Office of the South Carolina Attorney General. Providers, who have been sanctioned by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and are currently under suspension, shall not be allowed to participate in the SCHIP Program. Federal Financial Participation (FFP) is not available for services delivered by providers excluded by Medicare, Medicaid, or SCHIP except for emergency services. Failure to adhere to this provision may result in one or more of the following sanctions:

- 3.1.2.1 SCDHHS may withhold part or all of the capitation payment due on behalf of a member if service is provided or authorized by unlicensed personnel;
- 3.1.2.2 SCDHHS may refer the matter to the appropriate licensing authority for action;
- 3.1.2.3 SCDHHS may assess liquidated damages as described in **§13.3** or impose sanctions as required in **§13.5** of this Contract.

In the event SCDHHS discovers that the Contractor's subcontractor is not properly licensed by the appropriate authority, the Contractor shall immediately remove the subcontractor from its provider list and the subcontractor shall discontinue providing services to Medicaid MCO program members. Upon proper licensing by the appropriate authority and approval by SCDHHS, the Contractor may reinstate the subcontractor to provide services to Medicaid MCO program members.

### 3.2 Credentialing and Recredentialing of Staff

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

3.2.1 The process for periodic recredentialing shall be implemented at least every three years.

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

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

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

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

### 3.3 Training

The Contractor shall be responsible for training all of its employees, network providers, and subcontractors to ensure that they adhere to the SCHIP policies, procedures and regulations. The Contractor shall be responsible for conducting ongoing training on SCHIP policies and distribution of updates for its network providers/subcontractors. SCDHHS reserves the right to attend any and all training programs and seminars conducted by the Contractor. The Contractor shall provide SCDHHS a list of any marketing training dates, times and locations, at least fifteen (15) calendar days prior to the actual date of training.

### 3.4 Liaisons

The Contractor shall designate an employee of its administrative staff to act as liaison between the Contractor and SCDHHS for the duration of the Contract. SCDHHS Department of Managed Care will be the Contractor's point of contact and shall receive all inquiries regarding this Contract and all required reports unless otherwise specified in this Contract. The Contractor shall also designate a member of its senior management who shall act as a liaison between the Contractor's senior management and SCDHHS when such communication is required.

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

### 3.5 Material Changes

The Contractor shall notify SCDHHS immediately of all material changes affecting the delivery of care or the administration of its health care plan under this Contract. Material changes include, but are not limited to, changes in: composition of the Contractor's provider network, or subcontractor network, the Contractor's complaint and grievance procedures; health care delivery systems, or services, expanded services; benefits; geographic service area or payments; enrollment of a new population; procedures for obtaining access to or approval for health care services; and the Contractor's ability to meet enrollment levels. All changes must be approved in writing by SCDHHS. The Contractor must provide the SCHIP MCO Program member with a copy of all changes at least thirty (30) days prior to the intended date of the changes. SCDHHS shall make the final determination as to whether a change is material

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

### 3.6 Integrity of Professional Advice to Enrollees

Based on 42 CFR §457.985, the State must ensure through its contracts for coverage and services that its contractors comply with (a) Section 422.206(a) of this chapter, which prohibits interference with health care professionals' advice to enrollees and requires that professionals provide information about treatment in an appropriate manner; and (b) Sections 422.208 and 422.210 of this chapter, which place limitations on physician incentive plans, and information disclosure requirements related to those physician incentive plans, respectively.

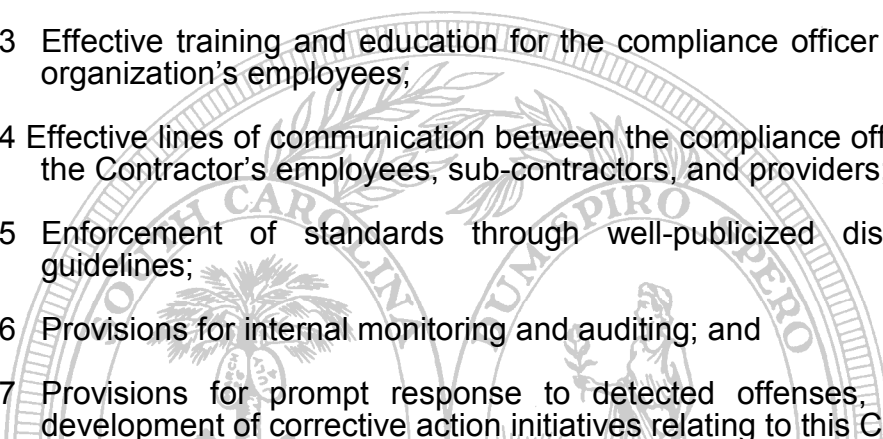
### 3.7 Notification of Legal Action

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

### 3.8 Fraud and Abuse Compliance/Program Integrity Plan

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



- 
- 3.8.1 Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable Federal and State standards and regulations;
  - 3.8.2 The designation of a compliance officer and a compliance committee that are accountable to senior management;
  - 3.8.3 Effective training and education for the compliance officer and the organization's employees;
  - 3.8.4 Effective lines of communication between the compliance officer and the Contractor's employees, sub-contractors, and providers;
  - 3.8.5 Enforcement of standards through well-publicized disciplinary guidelines;
  - 3.8.6 Provisions for internal monitoring and auditing; and
  - 3.8.7 Provisions for prompt response to detected offenses, and for development of corrective action initiatives relating to this Contract.

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

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

### 3.9 Ownership

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

### 3.10 Excluded Parties

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

## 4 SERVICES

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

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

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

### 4.1 Core Benefits For The South Carolina SCHIP Program

Core benefits shall be available to each Program member within the Contractor's service area and the Contractor shall provide a mechanism to reduce inappropriate and duplicative use of health care services. The Contractor:

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

The Contractor shall provide all of the core benefits consistent with and in accordance with the standards as defined in the SC Title XXI State Plan. Services shall be furnished up to the limits as specified in the service requirements outlined in the **Policy and Procedure Guide**, Core Benefits. A summary listing of the core benefits is as follows:

Physician Services  
Inpatient Hospital Services  
Transplants  
Outpatient Services  
Chiropractor Services  
Podiatry Services  
Well Care  
Emergency Medical Services  
Ancillary Medical Services

Immunizations  
Durable Medical Equipment  
Emergency Transportation  
Occupational, Speech and Physical Therapy  
Behavioral Health Disorders  
Rebated Prescription Drugs  
Home Health Care Services  
Skilled Nursing Care  
Applied Behavior Analysis Therapy Services  
Hospice  
Vision Care  
Rehabilitative Care  
Lab and X-ray

In the provision of core benefit services outlined and defined in the **Policy and Procedure Guide**, the Contractor shall be required to provide medically necessary and appropriate care to members under this Contract. See definition of “medically necessary service” in **Appendix A**. The SCDHHS shall make final interpretation of any disputes about the medical necessity and continuation of core benefits covered under this Contract.

The Contractor shall ensure the core benefits are provided as defined and specified in the **Policy and Procedure Guide**. Service limits such as a drug formulary may be implemented; however, there must be a mechanism to cover drugs outside the formulary if they are determined to be medically necessary in the treatment of a particular member. Information regarding coverage allowance for a non-formulary product shall be disseminated to members and providers.

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

- To SCDHHS with its application for a contract or whenever it adopts the policy during the term of the contract;
- To potential enrollees before and during Enrollment; and
- To enrollees within ninety (90) days after adopting the policy.

#### 4.2 Well Child Visits

The intent of well child services for members, ages birth through the month of their 19th birthday, is to direct attention to the importance of preventive health services and early detection and treatment of problems identified during a well child visit. The Contractor shall have written procedures for notification, tracking, and follow-up to ensure these services will be available to all eligible children.

The Contractor shall assure that all medically necessary, covered diagnosis, treatment services and screenings are provided, either directly, through subcontracting, or by referral. The utilization of these services shall be reported as referenced in the **Policy and Procedure Guide Expenditures** for the medical services as previously described have been factored into the capitated rate described in §2.1 of this Contract and the Contractor will not receive any additional payments.

#### 4.3 Emergency Medical Services

The Contractor shall provide that emergency and post-stabilization services be rendered without the requirement of prior authorization of any kind and advise all members of the provisions governing in and out of service area use of emergency services. The Contractor's protocol for provision of emergency services must specify the circumstances under which, the emergency services will be covered when furnished by a provider with which the Contractor does not have contractual or referral arrangements. The Contractor shall make prompt payment for covered emergency services that are furnished by providers that have no arrangements with the Contractor for the provision of such services. The attending emergency physician, or the provider actually treating the member, shall determine when the member is sufficiently stabilized for transfer or discharge.

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

The Contractor shall be responsible for payment to providers in and out of the network service area, without requiring prior approval, for the following services and in accordance with the Social Security Act (SSA) Section 1867 (42 U.S.C. §1395(dd): 1) Determining if an emergency exists for Program members when the medical screening service is performed, 2) Treatment as may be required to stabilize the medical condition, and for 3) Transfer of the individual to another medical facility within SSA Section 1867 (42 U.S.C. §1395dd) guidelines and other applicable state and federal regulations. Contractor shall prior approve any services performed after the provider, whether in or out of the network service area, has stabilized the patient. The Contractor shall cover services subsequent to stabilization: 1.) that were pre-approved by the Contractor, 2) were not pre-approved by the Contractor because the Contractor did not respond to the provider of post-stabilization care services' request for pre-approval within 1 hour after the request was made, 3) if the Contractor could not be contacted for pre-approval, and 4) if the Contractor and the treating physician cannot reach an agreement concerning the member's care and

a network physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a network physician and the treating physician may continue with the care of the member until a network physician is reached or one of the criteria of 42 CFR §422.113(c)(3) is met. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.

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

The Contractor shall not charge members for any post-stabilization care services. The Contractor's financial responsibility for post-stabilization care services it has not pre-approved ends when 1) a network physician with privileges at the treating hospital assumes responsibility for the member's care, 2) a network physician assumes responsibility for the member's care through transfer, 3) a representative of the Contractor and the treating physician reach an agreement concerning the member's care, or 4) the member is discharged.

#### 4.4 Limitations on Abortions

The Contractor shall perform abortions in accordance with 42 CFR §457.475. The Contractor will be reimbursed for abortion services only if (1) physical disorder, injury, or illness including a life-endangering physical condition caused by or arising from the pregnancy itself would, as certified by a physician, place the mother in danger of death unless an abortion is performed; or (2) the pregnancy is the result of an act of rape or incest. Abortions must be prior approved before the service is rendered to ensure compliance with the Federal Regulation. Abortions must be documented with a completed Abortion Statement Form and must meet the requirements as outlined in the **Policy and Procedure Guide** to satisfy state and federal regulations.

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

#### 4.5 Medical Services for Special Populations

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

The Contractor shall determine the need for any enhanced services that may be necessary for these populations to maintain their health and well being. The **Policy and Procedure Guide**, Best Practices, outlines the best practices and procedures that the SC Title XXI State Plan uses to serve the designated special populations. Expenditures for the health care services of the special populations as previously described have been factored into the capitated rate described in **§2.1** of this Contract and the Contractor will not receive any additional payments.

Children with chronic/complex health care needs are defined as a special population in the SC Title XXI State Plan. The special population is identified as individuals that may require additional health care services that should be incorporated into a health management plan, which guarantees that the most appropriate level of care is provided for these individuals.

#### 4.6 Excluded Services

The services set forth below will continue to be provided/reimbursed by the current Medicaid program as fee-for-service. Refer to the **Policy and Procedure Guide** for more detailed information on these services.

- Dental Services

For Ethical Limitations, refer to the **Policy and Procedure Guide** for more detailed information.

#### 4.7 Expanded Services/Benefits

The Contractor may offer expanded services and benefits to enrolled members in addition to those covered services specified in the **Policy and Procedure Guide** and this Contract. These services/benefits shall be specifically defined by the Contractor in regard to amount, duration and scope. SCDHHS will not provide any additional reimbursement for these services/benefits. The Contractor shall provide SCDHHS a description of the expanded services/benefits to be offered by the Contractor for approval, which shall be included and incorporated as a part hereof to the Contract and included in the Contractor's marketing information. Additions, deletions or modifications to expanded services/benefits made during the contract year must be submitted to SCDHHS for approval, in accordance with requirements listed in the **Policy and Procedure Guide**.

#### 4.8 Care Coordination

The Contractor shall ensure that each member has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the member. The Contractor shall be responsible for the planning, directing and coordinating of health care needs and services for members through care coordination, increased accessibility of services and promoting prevention. The Contractor's care coordination and referral activities must incorporate and identify appropriate methods of assessment and referral for members requiring

both medical and behavioral health services. These activities must include assessment, scheduling assistance, monitoring and follow-up for its member(s) needing or requiring both medical and behavioral health services.

#### 4.8.1 Referral System

The Contractor shall provide the coordination necessary for the referral of Program members to specialty providers. The Contractor shall provide SCDHHS a copy of its referral and monitoring process for services included in the core benefits and expanded services.

#### 4.8.2 Continuity of Care

The Contractor shall develop and maintain effective continuity of care activities, which seek to ensure a continuum approach to treating and providing health care services to members. In addition to ensuring appropriate referrals, monitoring, and follow-up to providers within the network, the Contractor shall ensure appropriate linkage and interaction with providers outside the network. The Contractor's continuity of care activities should seek to provide processes by which member and network provider interactions can effectively occur and identify and address problems when those interactions are not effective or do not occur.

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

Unless otherwise required by this Contract, the Contractor shall not be obligated to directly furnish or pay for any services outside the core benefits except those included in the expanded services/benefits as stipulated in this Contract. The Contractor shall assist the member in determining the need for services outside the core benefits and refer the member to the appropriate service provider.

#### 4.8.3 Women, Infant, and Children (WIC) Program Referral

The Contractor shall be responsible for ensuring that coordination exists between the WIC Program and network providers. Coordination shall include referral of potentially eligible women, infants and children and reporting of appropriate medical information to the WIC Program. SCDHEC administers the WIC Program. A sample referral/release of information form is found in the **Policy and Procedure Guide**, WIC Referral Form.

#### 4.8.4 Institutional Long-Term Care Facilities/Nursing Homes

The Contractor is responsible for reimbursing the long-term care facility/nursing home/hospital who provides swing beds or administrative days for the first sixty (60) days of services in any given episode of long-term care/nursing home placement as specified in the **Policy and Procedure Guide**.

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

If a child is placed in a long-term care facility/nursing home, the child's eligibility should be reevaluated for Medicaid by SCDHHS.

#### 4.8.5 Mental Health, Alcohol and Other Drug Abuse Assessment and Treatment Services

The Contractor is required to provide mental health, alcohol and other drug abuse assessment and treatment services.

#### 4.8.6 Communicable Disease Services

Communicable disease services are available to help control and prevent diseases such as sexually transmitted diseases (STD), tuberculosis (TB) and Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) infection. The Contractor shall make communicable disease services available to members.

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

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

##### 4.8.6.2 Control and Prevention of Communicable Diseases

SCDHEC is the state public health agency responsible for promoting and protecting the public's health and has the primary responsibility for the control and prevention of communicable diseases such as TB, STD, HIV/AIDS infection and vaccine preventable diseases. SCDHEC



provides a range of primary and secondary prevention services through its local health clinics to provide and/or coordinate communicable disease control services.

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

#### 4.8.6.3 Patient Confidentiality

The public state health agency will promote coordination of care while ensuring patient confidentiality. Notwithstanding §4.8.6 of this Contract, in compliance with S.C. Code Ann. §44-29-135 (Supp. 2000, as amended), for Program members who choose diagnosis and treatment for TB, STD and HIV/AIDS infection in the state public health clinics, information regarding their diagnosis and treatment will be provided to the Contractor's PCP assigned to that member only with the written consent of the member, unless otherwise provided by law.

#### 4.9 Manner of Service Delivery and Provision

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

- The anticipated enrollment;
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific populations represented by the Contractor;
- The number of network providers who are not accepting new SCHIP patients; and
- The geographic location of providers and members; considering distance travel time, means of transportation ordinarily used by this population, and whether the location provides physical access for members with disabilities.

When determined appropriate, the Contractor shall provide a second opinion from a qualified health care professional within the network or arrange for the member to obtain one outside the network at no cost to the member. If the network is unable to provide necessary covered services to a particular member, the Contractor shall adequately and timely cover these services out of network for the member for as long as the Contractor is unable to provide them.

#### 4.9.1 Service Area

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

#### 4.9.2 Adequacy of Providers

The Contractor shall maintain appropriate levels, as determined by SCDHHS, of organizational components, including, but not limited to, PCPs, specialty providers and other providers necessary for the provision of the services under this Contract.

The Contractor shall establish and maintain provider networks and in-area referral providers in sufficient numbers, as determined by SCDHHS, to ensure that all contracted services are available and accessible in a timely manner within the Contractor's service area in accordance with §4 and as approved by SCDHHS.

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

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

SCDHHS' detailed standards, criteria and requirements for county network submissions and ongoing review are located in the **Policy and Procedure Guide**.

Services to a Program member shall be provided in the same manner as those services that are provided to commercial members of the Contractor.

The Contractor shall notify SCDHHS immediately of any changes to the composition of its provider network and/or subcontractors that materially and adversely affects its ability to make available all core benefits in a timely manner in accordance with §4 of this Contract. The Contractor shall also have procedures to address changes in its provider network that negatively affect the ability of members to access services.

Material changes in provider network composition that are not prior approved by SCDHHS and/or that may impair the member's access to services will be considered as grounds for Contract termination.

The Contractor understands and agrees that notwithstanding the execution of this Contract, neither the Contractor nor its subcontractor/network provider shall provide any services until the Contractor has an adequate provider network verified and approved by SCDHHS.

In the event any county network(s) is found to be in violation of requirements stated in **§4.9.2, Adequacy of Providers**, SCDHHS reserves the right to implement the Provider Network Termination and/or Transition Plan, as described in the **Policy and Procedure Guide**.

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

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

#### 4.9.3 Contractor's Network Composition

The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification. The Contractor shall not discriminate for the participation, reimbursement, or indemnification of any provider who serves high-risk populations or specializes in conditions that require costly treatment. If the Contractor declines to include individuals or groups of providers in its network, it must give the effected providers written notice of the reason for its decision. The Contractor shall not be required to maintain specific member-to-specialist provider ratios. The Contractor shall provide adequate access, as determined by SCDHHS, either through employment or subcontracting, to providers for PCP referrals, specialty services and/or ancillary medical services to ensure that these services are available in accordance with **§4** of this Contract.

##### 4.9.3.1 PCPs

The provider who serves as the entry point into the health care system for the member. The PCP is responsible for providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital service and maintaining continuity of care as outlined in **§4** of this Contract. The PCP may practice in a solo or group setting or may practice in a clinic (i.e., Federally Qualified Health Center or Rural Health Center) or outpatient clinic. The

Contractor shall agree to provide at least one (1) full time equivalent (FTE) PCP per two thousand five hundred (2,500) members (SCHIP Program members and existing commercial members).

Each eligible member shall be given the opportunity to choose a specific PCP within the Contractor's provider network who will be responsible for the provision of primary care services and the coordination of all other health care needs. The Contractor shall assign a PCP to a member if the member fails to select a new PCP within the established timeframe or after a change in PCP has occurred (for example the PCP no longer participating). The Contractor shall submit to SCDHHS a copy of the procedures to be used to contact members for initial member education for approval prior to contract execution. These procedures shall adhere to the enrollment process and procedures outlined in §6 and the post enrollment procedures required in §8 of this Contract.

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

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

The PCP responsibilities shall include, at a minimum:

- 4.9.3.1.1 Managing the medical and health care needs of members to assure that all medically necessary services are made available in a timely manner;
- 4.9.3.1.2 Providing the coordination necessary for the referral of patients to specialists; and
- 4.9.3.1.3 Maintaining a medical record of all services rendered by the PCP and other referral providers.

#### 4.9.4 Specialty Providers

The specialty provider must comply with all applicable statutory and regulatory requirements of the SCHIP program and be Board Certified or Admissible.

Specialty Provider responsibilities shall include at a minimum:

4.9.4.1 Providing consultation summaries or appropriate periodic progress notes to the member's PCP on a timely basis, following a referral or routinely scheduled consultative visit; and

4.9.4.2 Notifying the member's PCP when scheduling a hospital admission or any other procedure requiring the PCP's approval.

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

4.9.5 Other Ancillary Medical Service Providers

Ancillary medical service providers including, but not limited to, ambulance services, durable medical equipment, home health services, pharmacies, and X-Ray/laboratories must be qualified to provide services. All services must be provided in accordance with applicable state and federal laws and regulations.

4.9.6 Hospital Providers

Hospital providers must be qualified to provide services. All services must be provided in accordance with applicable state and federal laws and regulations. Neonates who have received the maximal benefit of specialized care but are not yet ready to be discharged may be transported back to the hospital from which they originated, if appropriate (back transport). The hospital is responsible for determining if the neonate should be back transported.

4.10 Service Accessibility Standards

The Contractor and its network providers/subcontractors shall ensure access to health care services (distance traveled, waiting time, length of time to obtain an appointment, after-hour care) in accordance with the prevailing medical community standards in for the services provided under this Contract. SCDHHS will monitor the Contractor's service accessibility. The Contractor shall provide available, accessible and adequate numbers of institutional facilities, service locations, service sites, professional, allied and para-medical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-days-a-week basis, and shall take corrective action if any provider fails to comply. At a minimum, this shall include:

#### 4.10.1 Twenty-Four (24) Hour Coverage

The Contractor shall ensure that all emergency medical care is available on a twenty-four (24) hours a day, seven (7) days a week basis through its network providers, and shall maintain, twenty-four (24) hours per day, seven (7) days per week, telephone coverage to instruct Program members on where to receive emergency and urgent health care.

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

#### 4.10.2 Travel Time and Distance

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

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

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

#### 4.10.3 Scheduling/Appointment Waiting Times

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

- 4.10.3.1 Routine visits scheduled within four (4) to six (6) weeks;
- 4.10.3.2 Urgent, non-emergency visits within forty-eight (48) hours;
- 4.10.3.3 Emergent or emergency visits immediately upon presentation at a service delivery site; and
- 4.10.3.4 Waiting times that do not exceed forty-five (45) minutes for a scheduled appointment of a routine nature.

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

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

The Contractor's network providers/subcontractors shall not use discriminatory practices with regard to members such as separate waiting rooms, separate appointment days, or preference to private pay patients.

#### 4.11 Authorization and Referral System

The Contractor shall have a referral system for members requiring specialty health care services.

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

#### 4.12 Cultural Considerations

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

#### 4.13 Prior Authorization

In the event a Medicaid member entering the Contractor's MCO is receiving Medicaid covered pharmacy and/or durable medical equipment services the day before enrollment, whether such services were provided by another MCO or Medicaid fee-for-service, the Contractor shall be responsible for the costs of continuation of these services, without any form of prior approval and without regard to whether such services are being provided by contract or non-contract providers. The Contractor shall provide continuation of such services for up to thirty (30) calendar days or until the member may be transferred without disruption, whichever is less. The Contractor must also honor any prior authorization for pharmacy and/or durable medical equipment services issued while the member was enrolled in another MCO or the Medicaid fee-for-service program for a period of thirty (30) calendar days after the member's enrollment in the Contractor's MCO. In addition, for members with the following conditions, the Contractor must provide continuation of pharmaceutical services and/or honor prior authorization and additionally thirty (30) days for a total of up to sixty (60) calendar days or until the member may be transferred without disruption, whichever is less: major depression, schizophrenia, bipolar disorder, major anxiety disorder and attention-deficit/hyperactivity disorder. Additional information regarding this requirement may be found in the **Policy and Procedure Guide**.

## 5 SUBCONTRACTS

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

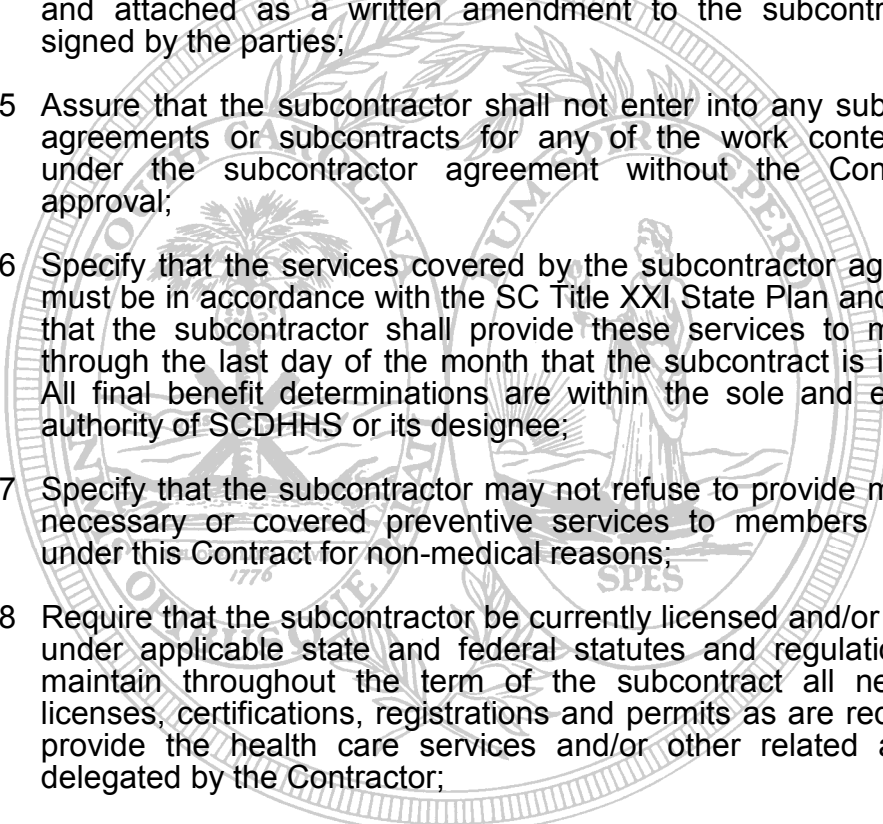
Model subcontracts for each health care provider type shall be submitted in advance to SCDHHS and shall include a copy of and specify that the subcontractor adhere to the QAPI requirements specified by SCDHHS in the **Policy and Procedure Guide, Quality Assessment and Utilization Management Requirements**.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

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

### 5.1 Subcontract Requirements

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



- 
- 5.1.1 Be in writing and signed by the Contractor and subcontractor;
  - 5.1.2 Specify the effective dates of the subcontractor agreement;
  - 5.1.3 Specify that the subcontractor agreement and its appendices contain all the terms and conditions agreed upon by the parties;
  - 5.1.4 Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties;
  - 5.1.5 Assure that the subcontractor shall not enter into any subsequent agreements or subcontracts for any of the work contemplated under the subcontractor agreement without the Contractor's approval;
  - 5.1.6 Specify that the services covered by the subcontractor agreement must be in accordance with the SC Title XXI State Plan and require that the subcontractor shall provide these services to members through the last day of the month that the subcontract is in effect. All final benefit determinations are within the sole and exclusive authority of SCDHHS or its designee;
  - 5.1.7 Specify that the subcontractor may not refuse to provide medically necessary or covered preventive services to members covered under this Contract for non-medical reasons;
  - 5.1.8 Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the Contractor;
  - 5.1.9 Specify the amount, duration and scope of services to be provided by the subcontractor;
  - 5.1.10 Provide that emergency services be rendered without the requirement of prior authorization of any kind;
  - 5.1.11 Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state and federal requirements;
  - 5.1.12 Require that an adequate record system be maintained for recording services, service providers, charges, dates and all other commonly accepted information elements for services rendered to members pursuant to the agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Contract). Members and their representatives shall be given access to and can request copies of the members' medical

records, to the extent and in the manner provided by S.C. Code Ann. §44-115-10 et seq., (Supp. 2000, as amended) subject to reasonable charges;

- 5.1.13 Provide that SCDHHS, the HHS, CMS, the Office of Inspector General, the State Comptroller, the State Auditor's Office, and the South Carolina Attorney General's Office shall have the right to evaluate, through audits, inspection, or other means, whether announced or unannounced, any records pertinent to this Contract including those pertaining to quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and practitioner claims submitted by the Contractor. The subcontractor shall cooperate with these evaluations and inspections;
- 5.1.14 Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the Contractor and/or SCDHHS or its designee;
- 5.1.15 Specify that the Contractor shall monitor the quality of services delivered under the agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Contractor/subcontractor practices and/or the standards established by SCDHHS or its designee;
- 5.1.16 Require that the subcontractor comply with any plan of correction initiated by the Contractor and/or required by SCDHHS;
- 5.1.17 Provide for submission of all reports and clinical information required by the Contractor, including well child care (if applicable);
- 5.1.18 Require safeguarding of information about members according to applicable state and federal laws and regulations and as described in **§13.20 and §13.28** of this Contract;
- 5.1.19 Provide the name and address of the official payee to whom payment shall be made;
- 5.1.20 Make full disclosure of the method and amount of compensation or other consideration to be received from the Contractor;
- 5.1.21 Provide for prompt submission of information needed to make payment;
- 5.1.22 Provide that the Contractor shall pay 90% of all clean claims from practitioners, either in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt. The Contractor shall pay 99% of all clean claims from practitioners, either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt. The date of receipt is the date the Contractor receives

the claim, as indicated by its data stamp on the claim. The date of payment is the date of the check or other form of payment. The MCO and its providers may, by mutual agreement, establish an alternative payment schedule. Any alternative schedule must be stipulated in the Contract;

- 5.1.23 Provide that subcontractors must submit all claims for payment no later than twelve (12) months from the date of service;
- 5.1.24 Specify that the subcontractor shall accept payment made by the Contractor as payment-in-full for covered services provided and shall not solicit or accept any surety or guarantee of payment from the member. Member shall include the patient, parent(s), guardian, spouse or any other person legally responsible for the member being served;
- 5.1.25 Specify that at all times during the term of the agreement, the subcontractor shall indemnify and hold SCDHHS harmless from all claims, losses, or suits relating to activities undertaken pursuant to the Contract between SCDHHS and the Contractor, unless the subcontractor is a governmental entity. For subcontractors that are not governmental entities, the indemnification may be accomplished by incorporating §13.25 of this Contract in its entirety in the subcontractor's agreement or by use of other language developed by the Contractor and approved by SCDHHS. For governmental entities, the liability protection may be accomplished by incorporating language developed by SCDHHS;
- 5.1.26 Require the subcontractor to secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect the plan's members and the Contractor under the agreement. The subcontractor shall provide such insurance coverage at all times during the agreement and upon execution of the subcontract agreement, shall furnish the Contractor with written verification of the existence of such coverage;
- 5.1.27 Specify that the subcontractor agrees to recognize and abide by all state and federal laws, regulations and guidelines applicable to the provision of services under the Program;
- 5.1.28 Provide that the agreement incorporates by reference all applicable federal and state laws or regulations, and that revisions of such laws or regulations shall automatically be incorporated into the agreement as they become effective. In the event that changes in the agreement as a result of revisions and applicable federal or state law materially affect the position of either party, the Contractor and subcontractor agree to negotiate such further amendments as may be necessary to correct any inequities;

- 5.1.29 Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the agreement termination date, or early termination of the agreement and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the agreement;
- 5.1.30 Specify that the Contractor and subcontractor recognize that in the event of termination of this Contract between the Contractor and SCDHHS for any of the reasons described in this Contract, the Contractor shall immediately make available to SCDHHS, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the Contractor's and subcontractor's activities undertaken pursuant to the Contractor/subcontractor agreement. The provision of such records shall be at no expense to SCDHHS;
- 5.1.31 Provide that the Contractor and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that all subcontracts must specify that no dispute shall disrupt or interfere with the provisions of services to the member including continuity of care should the subcontract be terminated;
- 5.1.32 Include a conflict of interest clause as stated in **§13.33** of this Contract between the Contractor and SCDHHS;
- 5.1.33 Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement and Utilization Management requirements as outlined in the **Policy and Procedure Guide**. The QAPI and UM requirements shall be included as part of the subcontract between the Contractor and the subcontractor;
- 5.1.34 Provide that all subcontractors shall give the Contractor immediate notification in writing by certified mail of any administrative legal action or complaint filed and prompt notice of any claim made against the subcontractor by a subcontractor, or a member which may result in litigation related in any way to this Contract with SCDHHS. The Contractor shall assure that all responsibilities related to the subcontract are performed in accordance with the terms of this Contract;
- 5.1.35 Contain no provision which provides incentives, monetary or otherwise, for the withholding of medically necessary care. See the **Policy and Procedure Guide, Incentive Plans**;
- 5.1.36 Specify that the subcontractor shall not assign any of its duties and/or responsibilities under this Contract without the prior written consent of the Contractor;
- 5.1.37 For any hospital subcontract, require that the hospitals notify the Contractor and SCDHHS of the births when the mother is a member of the Contractor's plan. The subcontract shall also specify that the hospital is responsible for completing SCDHHS

Request for Medicaid ID Number (Form 1716 ME), including indicating whether the mother is a member of an MCO, and submitting the form to the local SCDHHS/state SCDHHS office;

- 5.1.38 Specify that the Contractor shall not prohibit or otherwise restrict a network provider/subcontractor from advising a member about the health status of the member or medical care or treatment for the member's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the network provider/subcontractor is acting within the lawful scope of practice;
- 5.1.39 Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*) (2001, as amended) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the Provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement;
- 5.1.40 Contain no provision which restricts a network provider/subcontractor from contracting with another Managed Care Organization or other managed care entity;
- 5.1.41 Where the Contractor has entered into capitated reimbursement arrangements with providers, require submission of all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims;
- 5.1.42 Provide that all records originated or prepared in connection with the subcontractor's performance of its obligations under this Contract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the subcontractor in accordance with the terms and conditions of this Contract. The subcontract must further provide that the subcontractor agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of members relating to the delivery of care or service under this Contract, and as further required by SCDHHS, for a period of five (5) years from the expiration date of the Contract, including any Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five (5) year period, whichever is later. If the subcontractor stores records on microfilm or microfiche, the subcontractor must agree to produce, at its expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) calendar days of the request.

5.1.43 Require the subcontractor to report the required immunization data to the State Immunization Information System (SIIS) administered by the SCDHEC.

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

## 6 EDUCATION, SELECTION AND ENROLLMENT PROCESS

SCDHHS determines eligibility for SCHIP. Once an applicant is determined eligible by SCDHHS, the pertinent eligibility information is entered in the Medicaid Eligibility Determination System (MEDS). The rights afforded to potential members are detailed in the **Policy and Procedure Guide, Members' Bill of Rights**.

### 6.1 Enrolling Eligibles in the Contractor's Plan

SCDHHS' enrollment designee will assign new eligibles to an SCHIP plan using a sequential process. Eligibles will not initially choose a plan. When an eligible is enrolled in an SCHIP service plan, SCDHHS will enter the enrollment information as provided in **§6.2** of this Contract.

SCDHHS will provide the Contractor notification of the eligibles who are enrolled, re-enrolled, or disenrolled from its plan as specified in **§6.8**. The Contractor shall contact the members as required in **§8** of this Contract.

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

### 6.2 Enrollment Period

SCHIP members shall be enrolled for a period of twelve (12) months contingent upon their continued eligibility. SCHIP eligibility is different from Medicaid. Members cannot move from an SCHIP managed care plan to fee-for-service nor can the members move from an SCHIP managed care plan when there is only one SCHIP plan in the county.

The member may request disenrollment once, without cause, at any time during the ninety (90) calendar days following the date of the member's initial enrollment or re-enrollment. After this initial 90 days, the member

cannot change plans without cause. A member shall remain in the Contractor's plan unless the member submits a written, electronic or oral request to disenroll, or transfer to another plan for cause or the member becomes ineligible for enrollment.

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

A SCHIP program member who becomes disenrolled due to loss of eligibility but regains SCHIP eligibility within sixty (60) calendar days will be automatically enrolled in the Contractor's plan. Depending on the date eligibility is regained, there may be a gap on the member's MCO coverage. If SCHIP eligibility is regained after 60 days, the reinstatement of SCHIP eligibility will prompt the SCDHHS Enrollment Broker to mail an enrollment packet to the beneficiary. The beneficiary may also initiate the re-enrollment process without an enrollment packet. See **§6.6** for additional information on re-enrollment.

### 6.3 Selection or Assignment of a PCP

The Contractor shall contact the SCHIP Program member to assist the member in making a selection of a PCP, if a valid PCP is not selected at the time of enrollment. The Contractor shall inform the member that each family member has the right to choose his/her own PCP. The Contractor may explain the advantages of selecting the same PCP for all family members, as appropriate. The Contractor or SCDHHS shall confirm the PCP selection information in a written notice to the member.

### 6.4 Newborns

Babies born to SCHIP members are not automatically eligible. A separate application must be filed and an eligibility determination must be made by SCDHHS. See the **Policy and Procedure Guide**.

### 6.5 Contractor Follow-Up of Voluntary Disenrollees

The Contractor may conduct an initial follow up for all voluntary disenrollees. These members will be identified on the member listing file with a special indicator. SCDHHS will provide the Contractor with a member listing file (enrollments and disenrollments). The Contractor may contact the member upon receipt of the member listing file. However, follow-up must be within the guidelines outlined in the **Policy and Procedure Guide, Marketing, Member Education and Enrollment**.

### 6.6 Member Initiated Disenrollment and Change of Managed Care Plans

A member may request disenrollment from the MCO as follows:

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

A member's request to disenroll must be acted on no later than the first day of the second month following the month in which the member filed the request. If not, the request shall be considered approved.

#### 6.6.1 Member Disenrollment for Cause

A member may request disenrollment from the MCO for cause at any time. For cause disenrollment requests must be submitted to South Carolina Healthy Connections Choices (SCHCC), the SCDHHS's Enrollment Broker, on the appropriate form.

The following are considered cause for disenrollment by the member:

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

#### 6.6.2 Member Choice Period

A member may request disenrollment **once**, without cause, at any time during the ninety (90) calendar days following the date of the member's initial enrollment or re-enrollment with the MCO. The request and may be verbal, written or electronic and must be made to SCHCC.

#### 6.7 Contractor Initiated Member Disenrollment of Participation

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

- The Contractor ceases participation in the SCHIP program or in the member's service area;
- Member dies;
- Member becomes an inmate (see **Appendix A – Definition of Terms**) of a Public Institution;
- Member moves out of state or MCO's service area
- Member becomes institutionalized in a long term care facility/nursing home for more than sixty (60) days; or
- Member fails to follow the rules of the plan.



The Contractor must consider the fact that SCHIP members cannot choose fee-for-service. Members can only move from one SCHIP plan to another in their county of residence.

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

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

If the Contractor ceases participation in the eligible's service area or ceases participation in the SCHIP program, the Contractor shall notify SCDHHS in accordance with the termination procedures in **§13.2.10** of this Contract. SCDHHS will notify MCO program members and offer them the choice of another managed care plan in their service area. The Contractor shall assist the SCDHHS in transitioning SCHIP program members to another managed care plan to ensure access to needed health care services.

#### 6.8 SCDHHS Initiated Member Disenrollment

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

- Loss of SCHIP eligibility;
- Member's death;
- Member's intentional submission of fraudulent information;
- Member becomes an inmate (see **Appendix A – Definition of Terms**) of a public institution;
- Member moves out of state or MCO's service area;
- Member becomes Medicare Eligible;
- Member becomes institutionalized in a long-term care facility/nursing home for more than sixty (60) days; or
- Loss of the Contractor's participation.

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

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

6.9 Notification to Managed Care Plan of Membership

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

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

6.10 Toll Free Telephone Number

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

6.11 Tracking Slot Availability

The Contractor shall identify the maximum number of members it is able to enroll and maintain under this Contract. The Contractor agrees to provide services to members up to the maximum enrollment limits indicated for the Contractor in the **Policy and Procedure Guide**. SCDHHS reserves the right to approve or deny the maximum number of members to be enrolled in the Contractor's plan based on the determination of the adequacy of network capacity by SCDHHS.

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

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

## 6.12 Billing and Reconciliation

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

## 7 **MARKETING**

Marketing is defined as any communication and/or activity conducted on behalf of the Contractor that explicitly or implicitly refers to the Contractor's SCHIP participation and is targeted in any way toward SCHIP eligibles/recipients for the purpose of providing information regarding the Contractor's plan or can be reasonably interpreted as intended to influence the eligible/recipient to enroll in that particular plan, or either to not enroll, or to disenroll from, another plan.

All direct marketing to SCHIP applicants or recipients will be performed exclusively by SCDHHS or its designee. Direct marketing materials includes direct mail advertising, door-to-door, telephonic, or other "cold call" marketing. The Contractor shall not sponsor or attend any marketing activities without notifying SCDHHS. All marketing and educational materials must be approved by SCDHHS prior to use. All marketing, advertising and member education activities must comply with instructions as specified in the **Policy and Procedure Guide**.

SCDHHS may impose sanctions against the Contractor if SCDHHS determines that the Contractor distributed directly or indirectly or through any agent or independent contractor marketing materials and/or enrollment forms in violation of this contract, the **Policy and Procedure Guide** or federal law.

### 7.1 Information Provided to Enrollees

The Contractor shall provide each member with clear, accurate and truthful information about the Contractor's health plan to ensure compliance with this Contract and with state and federal laws and regulations. The Contractor shall ascertain whether the member has a PCP and if so, whether his/her PCP is a member of the MCO network. The Contractor must inform the recipient whether the doctor is a member of the Contractor's provider network. If the doctor is not a member of the Contractor's provider network, the recipient must be provided the Contractor's current provider listing from which he/she can choose a doctor. The Contractor shall be responsible for developing and distributing its own member specific marketing, educational and enrollment materials including but not limited to, evidence of coverage, member handbook, other materials designed for member education and enrollment form. All written material shall be written at a grade level no higher than the fourth (4th) grade, or as determined appropriate by SCDHHS. The Contractor shall not cause or knowingly permit the use of advertising that is untrue, misleading or deceptive. The Contractor shall inform the members that enrollment shall be for a period of twelve (12) months contingent upon their continued SCHIP eligibility and that the member may request disenrollment once without cause at any time during

the ninety (90) calendar days following the date of the member's initial enrollment. During marketing presentations, the Contractor must ask female recipients the name of the OB/GYN doctor they are currently using. The Contractor must inform the recipient whether the doctor is a member of the Contractor's provider network. If the doctor is not a member of the Contractor's provider network, the recipient must be provided the Contractor's current provider listing from which she can choose a doctor.

## 7.2 Marketing Plan and Materials

The Contractor shall develop and implement a marketing plan, for participation in the SCHIP Program. The Contractor shall describe the marketing activities it will undertake during the Contract period. The Contractor's marketing plan shall take into consideration the projected enrollment levels. The Contractor shall notify SCDHHS of its participation in each community event designed to increase community awareness of its participation in the SCHIP Program.

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

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

## 7.3 Approval of Marketing Plan and Materials

The Contractor shall submit to SCDHHS or its designee all marketing plans and written materials directed at SCHIP eligibles or potential eligibles for prior approval. These materials include, but are not limited to: materials produced for marketing, member education, evidence of coverage, member handbook and grievance procedures. Marketing materials include all types of media such as brochures, leaflets, newspapers, and magazines, and radio, television, billboard and yellow page advertisements directed at eligibles or potential eligibles. Marketing materials also include internet-based materials and methods of delivery such as Tweeter, etc .

## 8 POST ENROLLMENT PROCESS

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

### 8.1 Member Identification Card

The Contractor shall issue an identification (ID) card within fourteen (14) calendar days of the members' selection of a PCP or receipt of data from SCDHHS, whichever is later. A list of required ID card information is outlined in the **Policy and Procedure Guide**. If the Contractor has knowledge of any Program member permitting the use of this ID card by any other person, the Contractor shall immediately report this violation to SCDHHS or its designee. The Contractor shall also insure that its subcontractors/network providers can identify members, in a manner which will not result in discrimination against the members in order to provide or coordinate the provision of all core benefits and/or expanded services and out of plan services.

### 8.2 Member Services Availability

The Contractor shall maintain an organized, integrated member/patient services function, operated during regular business hours, to assist members with PCP selection, to explain the Contractor's policies and procedures (re: access and availability of health services), to provide additional information about the PCPs and/or specialist(s), to facilitate referrals to participating specialists, and to assist in resolving service and/or medical delivery problems and member complaints. The Contractor shall agree to maintain a toll-free telephone number for members' inquiries. The toll-free telephone number shall be required to provide prior authorization/access and information on services during evenings and weekends.

### 8.3 Member Education

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

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

The Contractor shall have written policies and procedures for educating Program members about their benefits.

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

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

#### 8.3.1 Member Handbook

The Contractor shall provide each member with a member handbook and other written materials. The member handbook shall be written at a reading comprehension level no higher than fourth (4th) grade, or as determined appropriate by SCDHHS and shall contain the minimum information as outlined in the **Policy and Procedure Guide**.

#### 8.4 Member's Rights and Responsibilities

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

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

## 9 GRIEVANCE AND APPEAL PROCEDURES

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

### 9.1 Definitions

#### 9.1.1 Action means:

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

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

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

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

9.1.1.5 The failure of the Contractor to act within the timeframes provided in **§9.7.1 of this Contract**.

9.1.2 Appeal means a request for review of an action.

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

### 9.2 General Requirements

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

## 9.2.2 Filing Requirements

### 9.2.2.1 Authority to file

9.2.2.1.1 A member may file a grievance at a Contractor level of appeal, and may request a State Fair Hearing once the Contractor's appeals process has been exhausted.

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

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

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

### 9.2.3 Procedures

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

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

## 9.3 Notice of Grievance and Appeal Procedures

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

## 9.4 Grievance/Appeal Records and Reports

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

The Contractor shall provide SCDHHS with a monthly written report of all grievances/appeals filed by the SCHIP members, to include: member's name and ID number, summary of grievances and/or appeals; date of filing; current status; resolutions; and any resulting corrective action. The Contractor will be responsible for promptly forwarding any adverse



decisions to SCDHHS for further review/action upon request by SCDHHS or the member. SCDHHS may submit recommendations to the Contractor regarding the merits or suggested resolution of any grievance/appeal. See the **Policy and Procedure Guide**.

## 9.5 Handling of Grievances and Appeals

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

### 9.5.1 General Requirements

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

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

9.5.1.2 Acknowledge receipt of each grievance and appeal.

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

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

9.5.1.3.2 Who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by SCDHHS, in treating the member's condition or disease:

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

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

9.5.1.3.2.3 A grievance or appeal that involves clinical issues.

### 9.5.2 Special Requirements for Appeals

The process for appeals must:

9.5.2.1 Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution.

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

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

9.5.2.4 Include, as parties to the appeal:

9.5.2.4.1 The member and his or her representative; or

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

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

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

## 9.6 Notice of Action

### 9.6.1 Language And Format Requirements

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

### 9.6.2 Content of Notice

The notice must explain the following:

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

9.6.2.2 The reasons for the action;

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

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

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

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

9.6.2.7 The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

### 9.6.3 Timing of Notice

The Contractor must mail the notice within the following timeframes:

9.6.3.1 For termination, suspension, or reduction of previously authorized covered services, at least ten (10) calendar days before the date of action, except as permitted under 42 CFR §§431.213 and 431.214.

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

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

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

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

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

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

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

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

9.6.3.6 For expedited service authorization decisions where a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than three (3) business days after receipt of the request for service.

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

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

## 9.7 Resolution and Notification

Basic rule. The Contractor must dispose of each grievance, resolve each appeal, and provide notice, as expeditiously as the member's health condition requires, but also within the timeframes established in **§9.7.1** below.

### 9.7.1 Specific Timeframes:

#### 9.7.1.1 Standard Disposition of Grievances

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

#### 9.7.1.2 Standard Resolution of Appeals

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

#### 9.7.1.3 Expedited Resolution of Appeals

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

## 9.7.2 Extension of Timeframes

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

9.7.2.1.1 The member requests the extension; or

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

### 9.7.2.2 Requirements Following Extension

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

## 9.7.3 Format of Notice

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

### 9.7.3.2 Appeals

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

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

## 9.7.4 Content of Notice of Appeal Resolution

The written notice of the resolution must include the following:

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

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

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

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

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

### 9.7.5 Requirements for State Fair Hearings

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

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

### 9.8 Expedited Resolution of Appeals

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

#### 9.8.1 Punitive Action

The Contractor must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.

#### 9.8.2 Action Following Denial of a Request for Expedited Resolution

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

9.8.2.1 Transfer the appeal to the timeframe for standard resolution in accordance with §9.7.1.2; and

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

#### 9.8.3 Failure to Make a Timely Decision

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

### 9.9 Continuation of Benefits while the Contractor Level Appeals and the State Fair Hearing are Pending

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

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

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

9.9.2 Continuation of Benefits

The Contractor must continue the member's benefits if:

9.9.2.1 The member or the provider files the appeal timely;

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

9.9.2.3 The services were ordered by an authorized provider;

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

9.9.2.5 The member requests extension of benefits.

9.9.3 Duration of Continued or Reinstated Benefits

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

9.9.3.1 The member withdraws the appeal.

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

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

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

9.9.4 Member Responsibility for Services Furnished While the Appeal is Pending

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

9.10 Grievance System Information

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

9.11 Recordkeeping and Reporting Requirements

Reports of grievances and resolutions shall be submitted to SCDHHS as specified in §§8.4, 9 and 10.4 of this Contract. The Contractor shall not modify the grievance procedure without SCDHHS' prior written approval.

9.12 Effectuation of Reversed Appeal Resolutions

9.12.1 Services Not Furnished While The Appeal Is Pending

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

9.12.2 Services Furnished While The Appeal Is Pending

If the Contractor or the State Fair Hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the Contractor or SCDHHS must pay for those services, in accordance with State policy and regulations.

**10 REPORTING REQUIREMENTS**

The Contractor is responsible for complying with all of the reporting requirements established by SCDHHS. The Contractor must demonstrate the capability to connect using TCP/IP protocol on a specific port using ConnectDirect software. Connectivity must be verified by SCDHHS in writing and the Contractor shall provide SCDHHS with a sample of all hard copy reports prior to Contract execution for prior approval. The requirements for electronic files can be found in the **Policy and Procedure Guide**. The Contractor shall provide SCDHHS and any of its designees with copies of agreed upon reports generated by the Contractor concerning any additional reports as requested in regard to performance under this Contract. SCDHHS will provide the Contractor with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. All reporting periods shall be based upon the calendar year unless otherwise specified. All reporting periods, Minimum Data Elements and required format for these reports are specified in the **Policy and Procedure Guide**. All reports shall be submitted in accordance with the schedule outlined in §13.3 of this Contract. In the event there are no instances to report, the Contractor shall submit null reports.

Additional reports may be required in the **Policy and Procedure Guide**. The Contractor shall certify all submitted data, documents and reports. The certification must attest, based on best knowledge, information, and belief (1) to the accuracy, completeness and truthfulness of the data; and (2) to the accuracy,



completeness and truthfulness of all documents and reports required by SCDHHS. The data that must be certified includes, but is not limited to, enrollment information, encounter data, health claims data, payment data, and other information required by SCDHHS, including information on subcontractors, and contained in contracts, proposals, and related documents in accordance with 42 CFR §§457.945 and 457.950. The data shall be certified by one of the following: (1) the Contractor's Chief Executive Officer (CEO); (2) the Contractor's Chief Financial Officer (CFO); or (3) an individual who has the delegated authority to sign for, and who reports directly to, the CEO or CFO. Certification shall be submitted concurrently with the certified data.

#### 10.1 Contractor's Network Providers and Subcontractors

The Contractor shall furnish to SCDHHS or its designee a monthly report of all network providers and subcontractors enrolled in the Contractor's plan, including but not limited to, PCPs, hospitals, home health agencies, pharmacies, medical vendors, specialty or referral providers and any other providers which may be enrolled for purposes of providing health care services to members under this Contract. The Contractor shall also furnish to SCDHHS or its designee adequate copies of the PCP listing as requested by SCDHHS. It shall be the Contractor's responsibility to assure confidentiality of the providers' identification numbers and indemnity of SCDHHS in accordance with **§13.26** of this Contract. SCDHHS is to be provided copies of all updates not less than ten (10) business days in advance of distribution. Any provider no longer taking new patients must be clearly identified. Any age restrictions for a provider must be clearly identified. The Minimum Data Elements and required format for this listing may be found in the **Policy and Procedure Guide**.

#### 10.2 Individual Encounter/Claim Data

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

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

encounter data can be resubmitted within the ninety (90) day limit. Submissions shall be comprised of encounter records, or adjustments to previously submitted records, which the Contractor has received and processed from provider encounter or claims records of any contracted services rendered to the Enrollee. Encounter data received from the Contractor will be enhanced and edited by standards established by SCDHHS. In addition to this requirement, the Contractor shall provide a monthly summary, which identifies the number of encounters submitted and identified by the date of service. This summary is due to the Department of Managed Care five (5) business days after the end of the month in a format specified in the **Policy and Procedure Guide**. SCDHHS will furnish an enhanced version of the encounter file (**Policy and Procedure Guide**) to the Contractor within a timeframe to be determined by SCDHHS. The enhanced version encounter record will contain additional data elements obtained from the Medicaid Management Information System (MMIS) and contain specific encounter/ edit information. The Contractor will receive an edit report (**Policy and Procedure Guide**) for each encounter submission.

#### 10.3 Abortion Reporting

The Contractor shall submit a monthly report of all therapeutic abortions performed. The report shall include medical records to support each abortion performed, a copy of the completed abortion statement and a copy of the police report if applicable. Please see the **Policy and Procedure Guide** for the Abortion Guidelines.

#### 10.4 Grievance/Appeal Log Summary Reporting

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

#### 10.5 Institutional-Long Term Care/Nursing Home Reporting

The Contractor shall notify SCDHHS or its designee when a member is accepted and approved for institutionalization in a long-term care facility/nursing home and again at the time the 60<sup>th</sup> day of placement is completed.

#### 10.6 Disenrollment Reporting

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

#### 10.7 Quality Assessment and Performance Improvement

The Contractor will submit reports of Quality Assessment and Performance Improvement (QAPI) activities, including, a QA Workplan, Plan of Correction (POC), Utilization Management (UM) activities and

Workplan, Program Integrity Workplan and Quality Measures documentation in accordance with the periodicity contained in §11 of this Contract and the **Policy and Procedure Guide**.

The Contractor shall collect information to report all HEDIS measures designated by SCDHHS in this Contract and the **MCO Policy and Procedure Guide**. The Contractor should collect HEDIS measures in calendar years 2010 and submit this information to SCDHHS. However, the Contractor is not required to submit audited HEDIS results to SCDHHS until June 15, 2012 for the 2011 calendar year. This requirement may be adjusted if the Contractor is in the process of obtaining NCQA certification but has not completed the entire process.

#### 10.8 Member Satisfaction Survey

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

#### 10.9 Additional Reports

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

#### 10.10 Ownership Disclosure

Federal laws require full disclosure of ownership, management, and control of prepaid health plans (42 CFR §§455.100-455.104), (2009, as amended). The Disclosure of Ownership and Control Interest Statement must be submitted to SCDHHS with this Contract; and resubmitted to SCDHHS prior to each Contract period or when any change in the Contractor's management, ownership or control occurs. The Contractor agrees to report any changes in ownership and disclosure information to SCDHHS at least thirty (30) calendar days prior to the effective date of the change.

#### 10.11 Information Related to Business Transactions

The Contractor agrees to furnish to SCDHHS or to HHS information concerning significant business transactions as set forth in 42 CFR §455.105 (2009, as amended). Failure to comply with this requirement may result in termination of this Contract.

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

1. The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of this request; and
2. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the five-year period ending on the date of this request.

For the purpose of this contract, "significant business transactions" means any business transaction or series of transactions during any of the fiscal year that exceed the amount of \$25,000 or 5% of the Contractor's total operating expenses.

#### 10.12 Information on Persons Convicted of Crimes

The Contractor agrees to furnish SCDHHS or HHS information concerning any person convicted of a criminal offense under a program relating to Medicare (Title XVIII), Medicaid (Title XIX or Title XXI) or the Social Services Block Grant Program (Title XX) as set forth in 42 CFR §455.106 (2009, as amended). Failure to comply with this requirement may lead to termination of this Contract.

#### 10.13 Errors

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

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

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

#### 10.14 Coding Requirements

The Contractor and its subcontractors must use the following coding sources when reporting data to SCDHHS. Neither the Contractor nor its subcontractors may redefine or substitute these required codes.

- 10.14.1 Diagnosis codes obtained from the International Classification of Disease 9<sup>th</sup> Edition Clinical Modification (ICD-9-CM).

- 10.14.2 Procedural codes obtained from the Physicians' Current Procedural Terminology (CPT) Code book; The Healthcare Common Procedure Coding System (HCPCS) Level II National Code book; and local assigned codes for which there is no national code.
- 10.14.3 UB-04 Codes obtained from the South Carolina Uniform Billing Manual.

## 11 QUALITY ASSESSMENT, MONITORING AND REPORTING

### 11.1 Quality Assessment and Performance Improvement

The Contractor will establish and implement a system of Quality Assessment and Performance Improvement (QAPI) as required by 42 CFR §§438.200-438.242 and a Utilization Management (UM) program as required by 42 CFR Part 456 and detailed within the **Policy and Procedure Guide**. The Contractor will submit annually by December 15<sup>th</sup> its QA Workplan, UM Workplan and Program Integrity Workplan to SCDHHS for review and approval. Any subsequent changes or revisions must be submitted to SCDHHS for approval prior to implementation.

The full scope of QAPI and UM requirements are outlined in the **Policy and Procedure Guide, Quality Assessment and Utilization Management Requirements**.

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

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

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

The Contractor must attain accreditation by the National Committee for Quality Assurance (NCQA). Accreditation must meet NCQA's 2012 accreditation standards, be completed by December 31, 2012, and be maintained during the life of this Contract. The Contractor must provide SCDHHS' Department of Managed Care with a copy of all correspondence with NCQA regarding the application process and the accreditation requirements. Failure to obtain NCQA accreditation by December 31, 2012 and maintain the accreditation thereafter shall be considered a breach of this Contract and shall result in its termination.

Achievement of provisional accreditation status shall require a POC within thirty (30) calendar days of receipt of the Final Report from NCQA and may result in termination of this Contract. Contractors who are NCQA accredited for the SCDHHS Medicaid Product as of December 31, 2012, may satisfy this requirement by adding the HCK product to the Contractor's NCQA accreditation at the time of their next Medicaid accreditation survey following the deadline.

#### 11.1.1 Quality Measures and HEDIS

The Contractor is required to conduct quality of care outcome studies, which include quality measures for HEDIS. Measures will include all Medicaid plan measures required by the NCQA for accreditation, in addition to measures specified in the **Policy and Procedure Guide**. HEDIS measures for calendar years 2009-2010 must be submitted to SCDHHS in the manner specified in the **Policy and Procedure Guide**. It is encouraged that the 2009-2010 measures be submitted in accordance with the NCQA-specified standards and auditing and submission process. Beginning with calendar year 2011 data, HEDIS measures must be submitted in accordance with the NCQA-specified standards and auditing and submission process. SCDHHS may impose liquidated damages, sanctions and/or restrict enrollment pending attainment of acceptable quality of care.

#### 11.1.2 Pay for Performance

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

### 11.2 Inspection, Evaluation and Audit of Records

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

The Contractor and all of its subcontractors shall make office work space available for any of the above mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provision of services under this Contract. If any litigation, claim, or other action involving the records has been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the five (5) year period, whichever is later. SCDHHS and/or any designee will also have the right to:

- 11.2.1 Inspect and evaluate the qualifications and certification or licensure of Contractor's subcontractors;
- 11.2.2 Evaluate, through inspection of the Contractor and its subcontractor's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to members;
- 11.2.3 Evaluate the Contractor's performance for the purpose of determining compliance with the requirements of the Contract;
- 11.2.4 Audit and inspect any of the Contractor's or its subcontractor's records that pertain to health care or other services performed under this Contract, determine amounts payable under this Contract, or the capacity of the Contractor to bear the risk of financial losses;
- 11.2.5 Audit and verify the sources of encounter data and any other information furnished by the Contractor in response to reporting requirements of this Contract, including data and information furnished by subcontractors;
- 11.2.6 Monitor enrollment and termination practices and ensure proper implementation of the Contractor's grievance procedures, in compliance with 42 CFR §§438.226-438.228 (2009, as amended). SCDHHS and/or its designee shall have access to all information related to complaints and grievances filed by members.

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

The Contractor also agrees that all statements, reports and claims, financial and otherwise, shall be certified as true, accurate, and complete, and the Contractor shall not submit for payment purposes those claims, statements, or reports which it knows, or has reason to know, are not properly prepared or payable pursuant to federal and state law, applicable regulations, this Contract, or SCDHHS policy.

### 11.3 Changes Resulting from Monitoring and Audit

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

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

#### 11.4 Medical Records Requirements

The Contractor will require network providers/subcontractors to maintain up-to-date medical records at the site where medical services are provided for each member enrolled under this Contract. Each member's record must be legible and maintained in detail consistent with good medical and professional practice, which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. The Contractor shall ensure within its own provider network that SCDHHS representatives or designees shall have immediate and complete access to all records pertaining to the health care services provided to members. Medical record requirements are further defined in the **Policy and Procedure Guide**.

#### 11.5 Record Retention

All records originated or prepared in connection with the Contractor's performance of its obligations under this Contract, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the Contractor and its subcontractors in accordance with the terms and conditions of this Contract.

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

#### 11.6 Program Integrity

In accordance with 42 CFR §457.950, the Contractor is required to provide the SCDHHS: (a) Enrollment information and other information required by the SCDHHS; (b) An attestation to the accuracy, completeness, and truthfulness of claims and payment data under penalty of perjury; (c) Access for the SCDHHS, the CMS and the HHS Office of the Inspector General (OIG) to enrollee health claims data and payment



data, in conformance with the appropriate privacy protections in the State; and (d) A guarantee that the MCO will not avoid costs for services covered in its Contract by referring enrollees to publicly supported health care resources.

## 12 SCDHHS RESPONSIBILITIES

### 12.1 SCDHHS Contract Management

SCDHHS will be responsible for the administrative oversight of the SCHIP Program. As appropriate, SCDHHS will provide clarification of policies, regulations and procedures. SCDHHS will be responsible for management of this Contract. All policy decision making or Contract interpretation will be made solely by SCDHHS. The management of this Contract will be conducted in the best interests of SCDHHS and Program members.

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

### 12.2 Payment of Capitated Rate

The Contractor shall be paid in accordance with the capitated rates specified in **Appendix B, Capitation Rate(s) and Rate Methodology**. These rates will be reviewed and adjusted periodically.

### 12.3 Required Submissions

Prior to execution of this contract, the plan shall submit to SCDHHS Required Submissions documents, as described in the **Policy and Procedure Guide**. SCDHHS shall have the right to approve, disapprove or require modification of these documents and any procedures, policies and materials related to the Contractor's responsibilities under this Contract. Upon approval of the Required Submissions, the Contractor shall submit a complete copy of all Required Submission documents in a format specified in the **Policy and Procedure Guide**. Thereafter, on January 15<sup>th</sup> of each year, the Contractor shall submit, in the aforementioned format, only additions, changes and modifications, which were submitted and approved during the previous year.

### 12.4 Immunization Data

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

### 12.5 Notification of SCHIP Program Policies and Procedures

SCDHHS will provide the Contractor with updates to appendices, information on and interpretation of all pertinent federal and state SCHIP regulations, and SCHIP Program policies, procedures and guidelines affecting the provision of services under this Contract. The Contractor will submit written requests to SCDHHS for additional clarification, interpretation bother information in a grid format specified by SCDHHS.

Provision of such information does not relieve the Contractor of its obligation to keep informed of applicable federal and state laws related to its obligations under this Contract.

#### 12.6 Provider Participation

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

#### 12.7 Quality Assessment and Monitoring Activities

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

SCDHHS or its designee, will at least annually monitor the operation of the Contractor for compliance with the provisions of this Contract, the **Policy and Procedure Guide**, and applicable federal and state laws and regulations. Inspection shall include the Contractor's facilities, as well as auditing and/or review of all records developed under this Contract including periodic medical audits, grievances, enrollments, disenrollments, termination, utilization and financial records, review of the management systems and procedures developed under this Contract and any other areas or materials relevant or pertaining to this Contract.

The Contractor shall have the right to review any of the findings and recommendations resulting from contract monitoring and audits. However, once SCDHHS finalizes the results of monitoring and/or auditing, the Contractor must comply with all recommendations resulting from the review. Failure to comply with recommendations for improvement may result in liquidated damages, sanctions and/or enrollment restrictions.

##### 12.7.1 Fee-for-Service Reporting to MCOs

SCDHHS will be responsible for providing MCOs with a recent retrospective fee-for-service history on all current members, if available. This history will go back a maximum of twenty-four (24) months from the month of initial plan membership.

##### 12.7.2 Request for Plan of Correction

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

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

### 12.7.3 External Quality Review

SCDHHS will perform periodic medical audits through contractual arrangements to determine if the Contractor furnished quality and accessible health care to members in compliance with 42 CFR §438.358 (2009, as amended). SCDHHS may contract with an External Quality Review Organization to perform the periodic medical audits and external independent reviews. The **Policy and Procedure Guide** lists SCDHHS external quality assessment evaluation requirements.

### 12.8 Marketing

SCDHHS, and/or its designee shall have the right to approve, disapprove or require modification of all marketing plans, materials, and activities, and member handbook materials developed by the Contractor pursuant to this Contract. See §7 of this Contract and the **Policy and Procedure Guide** for guidance.

### 12.9 Grievances/Appeals

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

### 12.10 Training

SCDHHS will conduct provider training and workshops on SCHIP policies and procedures as deemed appropriate for MCO Contractors.

### 12.11 Federal Fund Restrictions

The Contractor is responsible for accessing the OIG electronic data base and identifying, on a regular basis, information regarding individuals prohibited from receiving Federal funds.

## 13 **TERMS AND CONDITIONS**

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

### 13.1 Applicable Laws and Regulations

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

- 13.1.1 Title 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter D Part 457 (SCHIP);
- 13.1.2 S.C. Code Ann. §38-33-10 et seq. (Supp. 2000, as amended) and 25A S.C. Code Ann. Regs. §69-22 (Supp. 2000, as amended);
- 13.1.3 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. §7401, et seq.) and 20 U.S.C. §6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);
- 13.1.4 Title VI of the Civil Rights Act of 1964, as amended, (42 U.S.C. §2000d et seq.) and regulations issued pursuant thereto, 45 CFR Part 80; which provide that the Provider must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement;
- 13.1.5 Title VII of the Civil Rights Act of 1964, as amended, (42 U.S.C. §2000e) in regard to employees or applicants for employment;
- 13.1.6 Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. §794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;
- 13.1.7 The Age Discrimination Act of 1975, as amended, 42 U.S.C. §6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;
- 13.1.8 The Omnibus Budget Reconciliation Act of 1981, as amended, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;
- 13.1.9 The Balanced Budget Act of 1997, as amended, P.L. 105-33 and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;
- 13.1.10 The Americans with Disabilities Act, as amended, 42 U.S.C. §12101 et seq., and regulations issued pursuant thereto;
- 13.1.11 Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusion of Contractors for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

13.1.12 The Drug Free Workplace Acts, S.C. Code Ann. §§44-107-10 et seq. (Supp. 2000, as amended), and the Federal Drug Free Workplace Act of 1988 as set forth in 45 CFR Part 82, (2008, as amended); and

13.1.13 Title IX of the Education Amendments of 1972 regarding education programs and activities.

## 13.2 Termination

This Contract shall be subject to the following termination provisions. SCDHHS or its designee will give the Contractor written notice that the Contractor has failed to perform its contractual undertakings and may, at the discretion of SCDHHS, give the Contractor a specific time period in which to correct the deficiencies, unless other provisions in this section demand otherwise, before an actual notice of termination is issued. If SCDHHS determines that the Contractor has satisfactorily implemented corrective action, a notice of termination will not be issued. If SCDHHS determines that the Contractor has not satisfactorily corrected the problem(s), a notice of termination will be issued. SCDHHS will provide the Contractor with a written Notice of Intent to Terminate the contract between SCDHHS and the Contractor. The Notice of Intent to Terminate will include the date, time and location of a fair hearing before the SCDHHS Division of Appeals and Hearings. In the event of such termination, it is agreed that neither party shall be relieved from any financial obligations each may owe to the other. SCDHHS or its designee will assume responsibility for informing all affected members of the reasons for their termination from the Contractor. Members shall be allowed to disenroll immediately without cause.

### 13.2.1 Termination Under Mutual Agreement

Under mutual agreement, SCDHHS and the Contractor may terminate this Contract for any reason if it is in the best interest of SCDHHS and the Contractor. Both parties will sign a Notice of Termination which shall include, the date of termination, conditions of termination, and extent to which performance of work under this Contract is terminated.

### 13.2.2 Termination by SCDHHS for Breach

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

SCDHHS may terminate this Contract immediately if it is determined that actions by the Contractor or its subcontractor(s) pose a serious threat to the health of members enrolled in the Contractor's plan.

The Contractor will be paid for any outstanding monies due less any assessed damages. If damages exceed monies due, collection can be made from the Contractor's Fidelity Bond, Errors and Omissions Insurance, or any insurance policy or policies required under this Contract. The rights and remedies of the SCDHHS provided in this clause shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Contract.

#### 13.2.3 Termination for Unavailability of Funds

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

#### 13.2.4 Termination for Contractor Insolvency, Bankruptcy, Instability of Funds

The Contractor's insolvency or the filing of a petition in bankruptcy by or against the Contractor shall constitute grounds for termination for cause. If the SCDOI and SCDHHS determine the Contractor has become financially unstable and/or the Contractor's license is revoked, SCDHHS will immediately terminate this Contract upon written notice to the Contractor effective the close of business on the date specified.

#### 13.2.5 Termination for Convenience

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

#### 13.2.6 Termination by the Contractor

The Contractor shall give SCDHHS written notice of intent to terminate this Contract ninety (90) calendar days prior to the Contractor's intended last date of operation. Such written notice may be either hand-delivered to SCDHHS or may be mailed by certified mail, return receipt requested. The ninety (90) calendar days written notice shall specify the last date of operation, such date being at least ninety (90) calendar days after the date when SCDHHS receives the notice of termination. The Contractor shall comply with all terms and conditions stipulated in this Contract during the termination period. The Contractor may only terminate this Contract on the last calendar day of the month of termination.

### 13.2.7 Termination for Loss of Licensure or Certification

In the event that the Contractor loses its license issued by the SCDOI or the appropriate licensing agency to operate or practice in South Carolina, this Contract shall terminate as of the date of delicensure. Further, should the Contractor lose its certification to participate in the Title XXI program, as applicable, this Contract shall terminate as of the date of such decertification.

### 13.2.8 Termination for Noncompliance with the Drug Free Workplace Act

In accordance with S.C. Code Ann §44-107-60 (Supp. 2000, as amended), this Contract is subject to immediate termination, suspension of payment, or both if the Contractor fails to comply with the terms of the Drug Free Workplace Act.

### 13.2.9 Termination for Cause

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

13.2.9.1 A person with a direct or indirect ownership interest in the Contractor:

13.2.9.1.1 Has been convicted of a criminal offense under Sections 1128(a) 1128(b)(1), (2), or (3) of the SSA, in accordance with 42 CFR §1002.203; or

13.2.9.1.2 Has had civil monetary penalties or assessments imposed under Section 1128A of the Act; or

13.2.9.1.3 Has been excluded from participation in Medicare or any state health care program; and

13.2.9.1.4 Has a direct or indirect ownership interest or any combination therefore of 5% or more, is an officer if the Contractor is organized as a corporation, a partner if it is organized as a partnership, or an agent or a managing employee.

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

### 13.2.10 Termination Procedures

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

Subject to the provisions stated herein, once the notice of termination has been submitted to SCDHHS, the Contractor shall:

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

13.2.10.2 Immediately terminate all marketing procedures and subcontracts related to marketing;

13.2.10.3 Within ten (10) days of the Contractor's written notification to SCDHHS of its intent to terminate its contract, submit a termination plan to SCDHHS for review and approval. The Contractor shall make revisions to the plan as necessary or as required by SCDHHS and will resubmit the plan to SCDHHS for approval after each revision. Failure to submit a termination plan within ten (10) business days of written notification to SCDHHS of termination or to timely resubmit the plan after revisions may, in SCDHHS' discretion, result in a delay of the Contractor's planned termination date. Failure to submit a termination plan in the time specified in this provision shall result in a withhold of 25% of the Contractor's monthly capitation payment. These funds will be withheld until SCDHHS receives the termination plan.

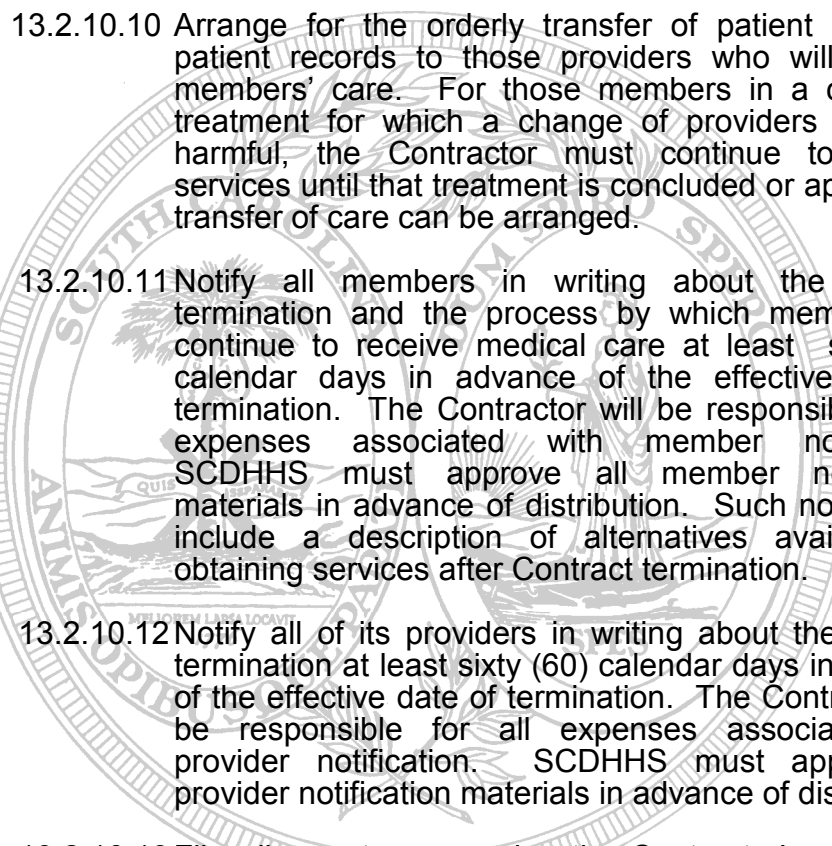
13.2.10.4 Agree to maintain claims processing functions as necessary for a minimum of nine (9) months (or longer if it is likely there are additional claims outstanding) in order to complete adjudication of all claims.

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

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

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



- 
- 13.2.10.8 Be financially responsible for member appeals of adverse decisions rendered by the MCO concerning treatment requested prior to the termination date which are subsequently determined in the member's favor after an appeal proceeding or a State Fair Hearing.
- 13.2.10.9 Assist SCDHHS with grievances and appeals for dates of services prior to the termination date.
- 13.2.10.10 Arrange for the orderly transfer of patient care and patient records to those providers who will assume members' care. For those members in a course of treatment for which a change of providers could be harmful, the Contractor must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged.
- 13.2.10.11 Notify all members in writing about the contract termination and the process by which members will continue to receive medical care at least sixty (60) calendar days in advance of the effective date of termination. The Contractor will be responsible for all expenses associated with member notification. SCDHHS must approve all member notification materials in advance of distribution. Such notice must include a description of alternatives available for obtaining services after Contract termination.
- 13.2.10.12 Notify all of its providers in writing about the contract termination at least sixty (60) calendar days in advance of the effective date of termination. The Contractor will be responsible for all expenses associated with provider notification. SCDHHS must approve all provider notification materials in advance of distribution.
- 13.2.10.13 File all reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract.
- 13.2.10.14 Take all actions necessary to ensure the efficient and orderly transition of participants from coverage under this Contract to coverage under any new arrangement authorized by SCDHHS.
- 13.2.10.15 To ensure fulfillment of its obligations before and after termination, maintain the financial requirements, fidelity bonds and insurance set forth in this Contract until SCDHHS provides the Contractor written notice that all obligations of this Contract have been met.
- 13.2.10.16 Submit reports to SCDHHS every thirty (30) calendar days detailing the Contractor's progress in completing its obligations under this Contract after the termination date. The Contractor, upon completion of these

obligations, shall submit a final report to SCDHHS describing how the Contractor has completed its obligations. SCDHHS shall, within twenty (20) calendar days of receipt of this report, advise in writing whether it agrees that the Contractor has met its obligations. If SCDHHS does not agree, then the Contractor shall complete the necessary tasks and submit a revised final report. This process shall continue until SCDHHS approves the final report.

- 13.2.10.17 Take whatever other actions are required by SCDHHS to complete this transition.
- 13.2.10.18 Be responsible for all financial costs associated with its termination, including but not limited to costs associated with changes to the enrollment broker's website and computer system, mailings and telephonic communications by the enrollment broker to the Contractor's members regarding their choice period after the termination effective date.
- 13.2.10.19 If applicable, assign to SCDHHS in the manner and extent directed by SCDHHS all the rights, title and interest of the Contractor for the performance of the subcontracts to be determined as needed in which case SCDHHS shall have the right, in its discretion, to resolve or pay any of the claims arising out of the termination of such agreements and subcontracts. The Contractor shall supply all information necessary for the reimbursement of any outstanding claims;
- 13.2.10.20 Complete the performance of such part of the Contract, which shall have not been terminated under the notice of termination;
- 13.2.10.21 Take such action as may be necessary, or as SCDHHS may direct, for the protection of property related to this Contract, which is in possession of the Contractor in which SCDHHS has or may acquire an interest;
- 13.2.10.22 In the event the Contract is terminated by SCDHHS, continue to serve or arrange for provision of services to the members of the Contractor until the effective date of termination. During this transition period, SCDHHS shall continue to pay the applicable capitation rate(s). Members shall be given written notice of the State's intent to terminate the contract and shall be allowed to disenroll immediately without cause;
- 13.2.10.23 Provide all necessary assistance to SCDHHS in transitioning members out of the Contractor's plan to the extent specified in the notice of termination. Such assistance shall include, but not be limited to, the

forwarding of all medical or financial records related to the Contractor's activities undertaken pursuant to this Contract; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, and hospitalized members, and pregnant members in their last four (4) weeks of pregnancy;

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

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

Any payments due under the terms of this Contract may be withheld until SCDHHS receives from the Contractor all written and properly executed documents and the Contractor complies with all requests of SCDHHS.

13.2.10.25 Once SCDHHS receives the notice of termination, SCDHHS shall:

13.2.10.25.1 Stop auto-assignment of members to the terminating plan as of the date written notification of termination is received by SCDHHS.

13.2.10.25.2 Review, revise and approve the Contractor's termination plan and final report.

13.2.10.25.3 Review, revise and approve all correspondence to the Contractor's members and providers prior to distribution.

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

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

### 13.2.11 Effect of Termination on the Contractor's HIPAA Privacy Requirements

13.2.11.1 Except as provided in **Section 13.2.11.2** below, upon termination of this Contract, for any reason, the Contractor shall return or destroy all PHI received from SCDHHS, or created or received by the Contractor on behalf of SCDHHS. This provision shall apply to PHI that is in the possession of subcontractors or agents of the Contractor. The Contractor shall retain no copies of the PHI.

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

### 13.3 Liquidated Damages for Failure to Meet Contract Requirements

It is agreed by SCDHHS and the Contractor that in the event of the Contractor's failure to meet the requirements provided in this Contract and/or all documents incorporated herein, damage will be sustained by SCDHHS. The actual damages which SCDHHS will sustain in the event of and by reason of such failure are uncertain, and extremely difficult and impractical to ascertain and determine. The parties therefore agree that the Contractor shall pay SCDHHS liquidated damages in the fixed amount as stated below; provided however, that if it is finally determined that the Contractor would have been able to meet the Contract requirements listed below but for SCDHHS' failure to perform as provided in this Contract, the Contractor shall not be liable for damages resulting directly there from. SCDHHS may impose liquidated damages upon the Contractor when it fails to timely and accurately submit any reports required under this Contract or the **Policy and Procedure Guide**.

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

Liquidated damages for late reports or deliverables shall begin on the first day the report is late. Liquidated damages for incorrect reports or deficient deliverables shall begin on the sixteenth day after date on the written notice provided by SCDHHS to the Contractor that the report remains incorrect or the deliverables remain deficient. For the purposes of determining liquidated damages in accordance with this section, reports or deliverables are due in accordance with the following schedule:

<u>Deliverables</u>	<u>Date Agreed Upon</u>
Daily Reports	Within two (2) business days
Weekly Reports	Wednesday of the following week
Monthly Reports	15th of the following month
Quarterly Reports (non-encounter reports)	30th of the following month
Annual Reports	Ninety (90) calendar days after the end of the year
On Request/Additional Reports	Within three (3) business days from the date of request unless otherwise specified by SCDHHS
Encounter data – initial submission	Twenty-five (25) calendar days after the end of the month in which it was paid
Encounter data – 100% accurate Submission	Ninety (90) calendar days after the date of initial submission

**Liquidated Damages**

Employment of licensed personnel	\$500.00 per calendar day for each day that personnel are not licensed as required by applicable state and federal laws and/or regulations. (See also §3.1.2 of this Contract)
Failure to complete corrective action as described in §§11 and 13.7	\$1500.00 per calendar day for each day the corrective action is not completed in accordance with the timeline established in the Plan of Correction
Late, incorrect or deficient reports, including HEDIS reports, and Encounter data initial submission,	\$1500.00 per calendar day per file or report
Encounter Data – failure to meet 100% accurate submission deadline as set forth in §10.2	\$1500.00 per calendar day

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

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

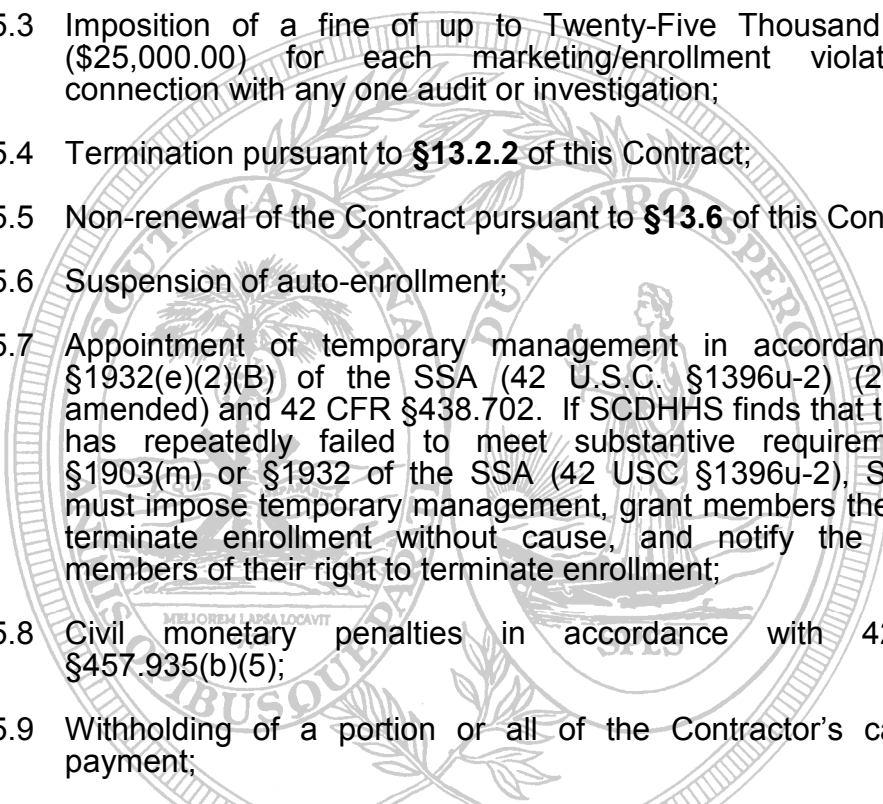
Whenever SCDHHS reasonably determines, based on identified facts and documentation, that the Contractor is failing to meet material obligations and performance standards described in this Contract, it may suspend the Contractor's right to enroll new members and impose any other sanctions in accordance with **§13.5**. SCDHHS, when exercising this option, shall notify the Contractor in writing of its intent to suspend new enrollment. The suspension period may be for any length of time specified by SCDHHS, or may be indefinite. SCDHHS also may notify members of the Contractor's non-performance and permit these members to transfer to another health plan following implementation of the suspension.

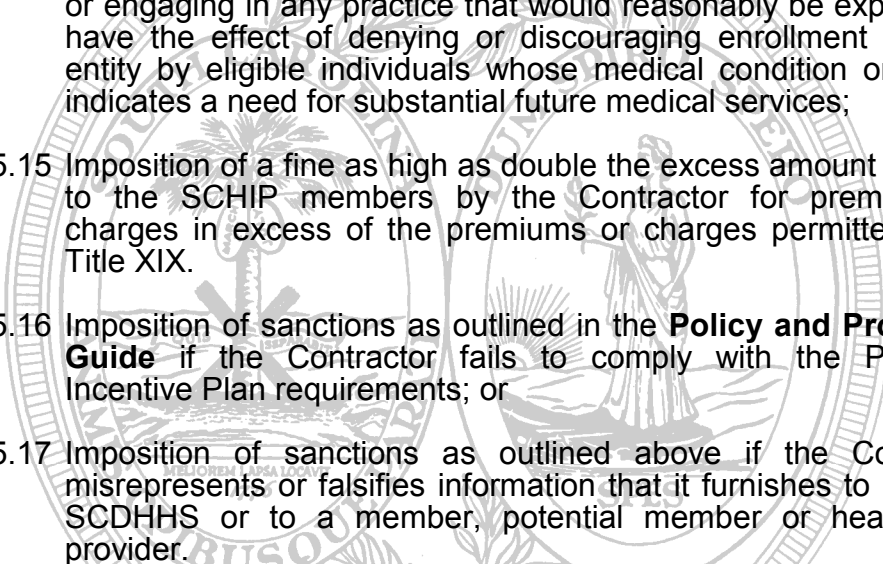
#### 13.4 Use of Data

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

#### 13.5 Sanctions

If SCDHHS determines that the Contractor has violated any provision of this Contract, or the applicable statutes or rules governing prepaid health plans, SCDHHS may impose sanctions against the Contractor. SCDHHS shall notify the Contractor and CMS in writing of its intent to impose sanctions and explain the Contractor's due process rights. Sanctions shall be in accordance with §1932 of the Social Security Act (42 U.S.C. §1396u2) and 42 CFR §§438.700-730 (2009, as amended) and may include any of the following:

- 
- 13.5.1 Suspension of payment for recipients enrolled after the effective date of the sanction and until CMS or SCDHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. This violation may result in recoupment of capitated payment.
- 13.5.2 Suspension of all marketing activities permitted under this Contract;
- 13.5.3 Imposition of a fine of up to Twenty-Five Thousand Dollars (\$25,000.00) for each marketing/enrollment violation, in connection with any one audit or investigation;
- 13.5.4 Termination pursuant to **§13.2.2** of this Contract;
- 13.5.5 Non-renewal of the Contract pursuant to **§13.6** of this Contract;
- 13.5.6 Suspension of auto-enrollment;
- 13.5.7 Appointment of temporary management in accordance with §1932(e)(2)(B) of the SSA (42 U.S.C. §1396u-2) (2001, as amended) and 42 CFR §438.702. If SCDHHS finds that the MCO has repeatedly failed to meet substantive requirements in §1903(m) or §1932 of the SSA (42 USC §1396u-2), SCDHHS must impose temporary management, grant members the right to terminate enrollment without cause, and notify the affected members of their right to terminate enrollment;
- 13.5.8 Civil monetary penalties in accordance with 42 CFR §457.935(b)(5);
- 13.5.9 Withholding of a portion or all of the Contractor's capitation payment;
- 13.5.10 Permitting individuals enrolled in the Contractor's plan to disenroll without cause. SCDHHS may suspend or default all enrollment of beneficiaries after the date the Secretary or SCDHHS notifies the Contractor of an occurrence under §1903(m) or section 1932(e).of the Social Security Act;
- 13.5.11 Terminating the contract if the Contractor has failed to meet the requirements of sections 1903(m), 1905(t)(3) or 1932(e) of the SSA and offer the Contractor's members an opportunity to enroll with other Contractors. SCDHHS shall provide the Contractor a hearing before the SCDHHS Division of Appeals and Hearings before termination occurs. SCDHHS will notify the members enrolled in the Contractor's plan of the hearing and allow the members to disenroll, if they choose, without cause;
- 13.5.12 Imposition of sanctions pursuant to §1932(e)(B) of the SSA if the Contractor does not provide abortion services as provided under the Contract at **§4**;

- 
- 13.5.13 Imposition of a fine of up to Twenty-five Thousand Dollars (\$25,000) for each occurrence of the Contractor's failure to substantially provide medically necessary items and services that are required to be provided to a member covered under the Contract;
- 13.5.14 Imposition of a fine of up to Fifteen Thousand Dollars (\$15,000) per individual not enrolled and up to a total of One Hundred Thousand Dollars (\$100,000) per each occurrence, when the Contractor acts to discriminate among members on the basis of their health status or their requirements for health care services. Such discrimination includes, but is not limited to, expulsion or refusal to re-enroll an individual, except as permitted by Title XXI, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the entity by eligible individuals whose medical condition or history indicates a need for substantial future medical services;
- 13.5.15 Imposition of a fine as high as double the excess amount charged to the SCHIP members by the Contractor for premiums or charges in excess of the premiums or charges permitted under Title XIX.
- 13.5.16 Imposition of sanctions as outlined in the **Policy and Procedure Guide** if the Contractor fails to comply with the Physician Incentive Plan requirements; or
- 13.5.17 Imposition of sanctions as outlined above if the Contractor misrepresents or falsifies information that it furnishes to CMS, to SCDHHS or to a member, potential member or health care provider.

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

### 13.6 Non-Renewal

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

### 13.7 Plan of Correction Required (Contract Non-Compliance)

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



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

Failure of the Contractor and/or its subcontractor(s) to implement and follow the plan of correction as approved by SCDHHS shall subject the Contractor to the actions stated in §§13.2, 13.3 and 13.5 including all subsections of this Contract.

#### 13.8 Inspection of Records

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

#### 13.9 Non-Waiver of Breach

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

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

#### 13.10 Non-Assignability

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

#### 13.11 Legal Services

No attorney-at-law shall be engaged through use of any funds provided by SCDHHS pursuant to the terms of this Contract. Further, with the exception of attorney's fees awarded in accordance with S.C. Code Ann.

§15-77-300 (2000, as amended), SCDHHS shall under no circumstances become obligated to pay an attorney's fee or the costs of legal action to the Contractor. This covenant and condition shall apply to any and all suits, legal actions, and judicial appeals of whatever kind or nature to which the Contractor is a party.

#### 13.12 Attorney's Fees

In the event that SCDHHS shall bring suit or action to compel performance of or to recover for any breach of any stipulation, covenant, or condition of this Contract, the Contractor shall and will pay to SCDHHS such attorney's fees as the court may adjudge reasonable in addition to the amount of judgment and costs.

#### 13.13 Independent Contractor

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

#### 13.14 Governing Law and Place of Suit

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

#### 13.15 Severability

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

#### 13.16 Copyrights

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

### 13.17 Subsequent Conditions

The Contractor shall comply with all requirements of this Contract and SCDHHS shall have no obligation to enroll any Program members into the Contractor's plan until such time as all of said requirements have been met.

### 13.18 Incorporation of Schedules/Appendices

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

### 13.19 Titles

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

### 13.20 Safeguarding Information

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

- 13.20.1 Be at least as restrictive as those imposed by 42 CFR Part 431, Subpart F (2009, as amended) and 27 S.C. Code Ann. Regs. §126-170 et seq. (Supp. 2009, as amended);
- 13.20.2 State that in the event of a conflict between the Contractor's written safeguard standards and any other state or federal confidentiality statute or regulation, the Contractor shall apply the stricter standard;
- 13.20.3 Require the written authorization of the member or potential member before disclosure of information about him or her except in those instances where state or federal statutes or regulations require disclosure or allow disclosure without the authorization of the member or potential member;
- 13.20.4 Only allow the release of statistical or aggregate data that has been de-identified in accordance with federal regulations at 45 CFR §164.514 and which cannot be traced back to particular individuals; and
- 13.20.5 Specify appropriate personnel actions to sanction violators.

### 13.21 Release of Records

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

## 13.22 Fraudulent Activity

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

- 13.22.1 the number of complaints of fraud and abuse made to the Contractor that warrant preliminary investigation.
- 13.22.2 For each case of suspected provider fraud and abuse that warrants a full investigation:
  - 13.22.2.1 the provider's name and number
  - 13.22.2.2 the source of the complaint
  - 13.22.2.3 the type of provider
  - 13.22.2.4 the nature of the complaint
  - 13.22.2.5 the approximate range of dollars involved
  - 13.22.2.6 the legal and administrative disposition of the case

The Contractor shall adhere to the policy and process contained in the **Policy and Procedure Guide** for referral of cases and coordination with the SCDHHS Division of Program Integrity for fraud and abuse complaints regarding members and providers.

## 13.23 Fraud and Abuse Compliance Plan

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

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

## 13.24 Integration

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

novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

### 13.25 Hold Harmless

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

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

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

### 13.26 Hold Harmless as to the SCHIP Program Members

In accordance with the requirements of S.C Code Ann. §38-33-130(b) (Supp. 2001, as amended), and as a condition of participation as a health care provider, the Contractor hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Program members of the Contractor, or persons acting on their behalf, for health care services which are rendered to such members by the Contractor and its subcontractors, and which are covered benefits under the member's evidence of coverage. This provision applies to all covered health care services furnished to the member for which SCDHHS does not pay the Contractor or SCDHHS or the Contractor does not pay the individual or health care provider that furnishes the services under a contractual, referred, or other arrangement during the time the member is enrolled in, or otherwise entitled to, benefits promised by the Contractor. The Contractor further agrees that the member shall not be held liable for payment for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the plan provided the service directly. The Contractor agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by the Contractor and insolvency of the Contractor. The Contractor further agrees that this provision shall be construed to be for the benefit of members of the Contractor, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Contractor and such members, or persons acting on their behalf.

### 13.27 Non-Discrimination

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

### 13.28 Confidentiality of Information

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

All information as to personal facts and circumstances concerning members or potential members obtained by the Contractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of SCDHHS or the

member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Contract.

### 13.29 Rate Adjustment

The Contractor and SCDHHS both agree that the capitation rates identified in **Appendix B** of this Contract shall remain in effect during the period identified on the Capitation Rates Schedule. Rates may be adjusted during the contract period based on SCDHHS and actuarial analysis.

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

### 13.30 Employment of Personnel

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

### 13.31 Political Activity

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

### 13.32 Force Majeure

The Contractor shall not be liable for any excess costs if the failure to perform the Contract arises out of causes beyond the control and without the fault or negligence of the Contractor. Such causes may include, but are not restricted to, acts of God or of the public enemy, acts of the Government in either its sovereign or contractual capacity, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather; but in every case the failure to perform must be beyond the control and without the fault or negligence of the Contractor. If the failure to perform is caused by default of a subcontractor, and if such default arises out of causes beyond the control of both the Contractor and subcontractor, and without the fault or negligence of either of them, the Contractor shall not be liable for any excess costs for failure to perform, unless the supplies or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required delivery schedule.

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

### 13.33 Conflict of Interest

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

### 13.34 Safety Precautions

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

### 13.35 Contractor's Appeal Rights

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



### 13.36 Loss of Federal Financial Participation (FFP)

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

### 13.37 Sharing of Information

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

### 13.38 HIPAA Compliance

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

### 13.39 Prohibited Payments

Payment for the following shall not be made:

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

### 13.40 HIPAA Business Associate

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

#### 13.41 Employee Education about False Claims Recovery

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

#### 13.42 Software Reporting Requirement

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

#### 13.43 National Provider Identifier

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

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

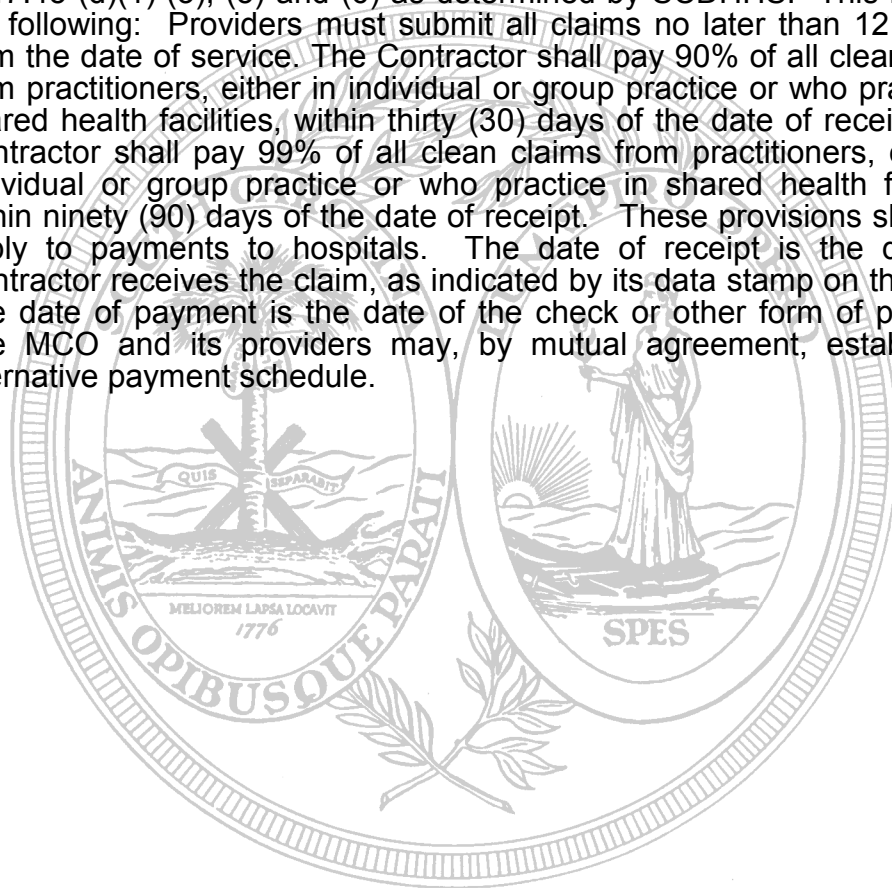
#### 13.44 Debarment/Suspension/Exclusion

The Contractor agrees to comply with all applicable provisions of 2 CFR Part 376 (2009, as amended), pertaining to debarment and/or suspension. As a condition of enrollment, the Contractor should screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program, and/or all federal health care programs. To make this determination, the Contractor may search the LEIE website located at <http://www.oig.hhs.gov/fraud/exclusions.asp>. The Contractor should conduct a search of the website monthly to capture exclusions and reinstatements that have occurred since the last search, and any exclusion information discovered should be immediately reported to SCDHHS. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider. This prohibition applies even when the Medicaid payment itself is made to another provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid beneficiary cannot claim reimbursement from SCHIP for that prescription.

Civil monetary penalties may be imposed against providers who employ or enter into contracts with excluded individuals or entities to provide items or services to SCHIP beneficiaries. See Section 1128A(a)(6) of the Social Security Act and 42 CFR 1003.102(a)(2).

#### 13.45 Payment of Providers

Payment of both contracted and non-participating providers shall, at a minimum, follow the same standards as those contained in 42 CFR §447.45 (d)(1)-(3), (5) and (6) as determined by SCDHHS. This includes the following: Providers must submit all claims no later than 12 months from the date of service. The Contractor shall pay 90% of all clean claims from practitioners, either in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt. The Contractor shall pay 99% of all clean claims from practitioners, either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt. These provisions shall also apply to payments to hospitals. The date of receipt is the date the Contractor receives the claim, as indicated by its data stamp on the claim. The date of payment is the date of the check or other form of payment. The MCO and its providers may, by mutual agreement, establish an alternative payment schedule.



IN WITNESS WHEREOF, SCDHHS and the Contractor, by their authorized agents, have executed this Contract as of the first day of April 2010.

SOUTH CAROLINA DEPARTMENT OF  
HEALTH AND HUMAN SERVICES  
"SCDHHS"

"CONTRACTOR"

BY: \_\_\_\_\_  
Emma Forkner  
Director

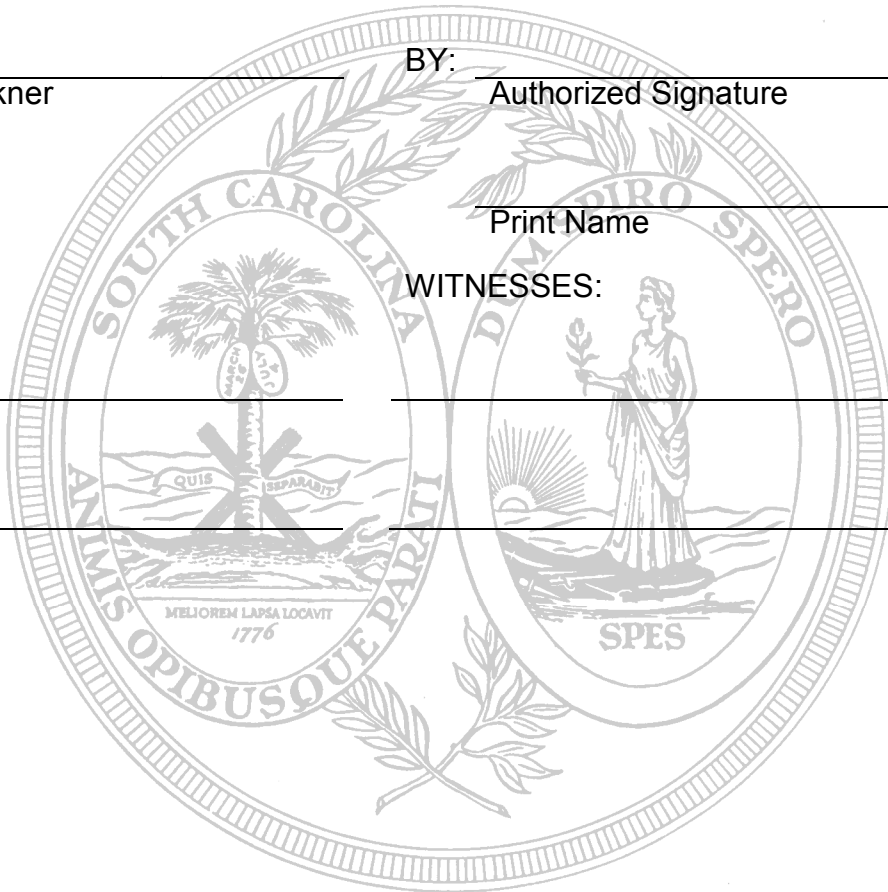
BY: \_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Print Name

WITNESSES:

WITNESSES:

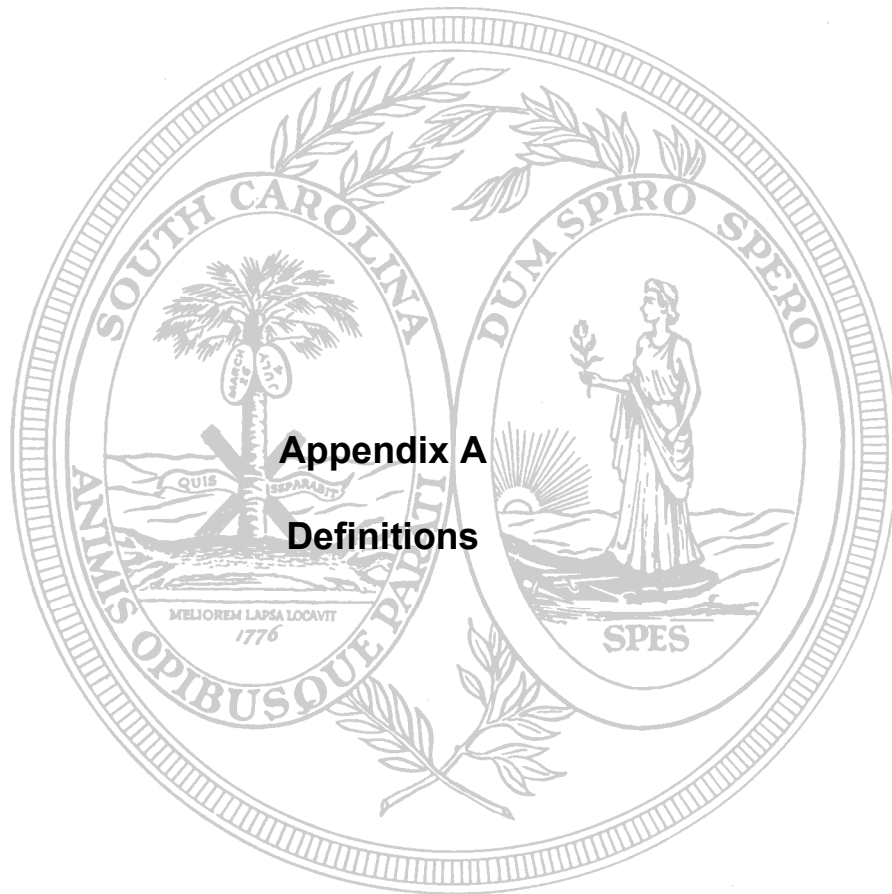
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



The seal of the State of South Carolina is centered on the page. It features a circular border with the text "SOUTH CAROLINA" at the top and "ANIMIS OPIBUSQUE PARATI" at the bottom. Inside the seal, there are two ovals. The left oval depicts a palmetto tree with a date "MARCH 20" and "JULY" on its trunk, and a banner below it that reads "QUIS SEPARABIT". Below this oval is the motto "MELIOREM LAPSA LOCAVIT" and the year "1776". The right oval shows a female figure holding a torch, with the motto "DUM SPIRO SPERO" above her and "SPES" below her.

**LIST OF APPENDICES**

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



**Appendix A**  
**Definitions**

## DEFINITION OF TERMS AND ACRONYMS

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

AAFP – Academy of Family Physicians

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the SCHIP 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 SCHIP program.

ACIP – Centers for Disease Control Advisory Committee on Immunization Practices

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

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

Applicant - An individual seeking SCHIP eligibility through written application

CFR - Code of Federal Regulations

CPT - Current Procedural Terminology, fourth edition, revised 2007

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

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

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

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

Case - An event or situation

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

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

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

CMS – Centers for Medicare and Medicaid Services

CMS 1500 - Universal claim form, required by CMS, to be used by non-institutional and institutional Contractors that do not use the UB-92.

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

Co-payment - Any cost-sharing payment for which the SCHIP MCO Program member is responsible for in accordance with 42 CFR, §457 Subpart E

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

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

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

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



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

Covered Services - Services included in the South Carolina State SCHIP Plan.

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

DAODAS - Department of Alcohol and Other Drug Abuse Services

DDSN - Department of Disabilities and Special Needs

DHEC - Department of Health and Environmental Control

Days - Calendar days unless otherwise specified.

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

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

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

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

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

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

Encounter - any service provided to a SCHIP Program member regardless of how the service was reimbursed and regardless of provider type, practice specialty, or place of services. This would include expanded services/benefits as defined in this Contract.

Enrollment - The process in which a SCHIP eligible is assigned to a plan or selects a plan and goes through a managed care educational process as provided by SCDHHS or its agent.

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

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

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

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

FPL - Federal Poverty Level

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

FTE - A full time equivalent position

FQHC - A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants. An FQHC provides a wide range of primary care and enhanced services in a medically underserved area.

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

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

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

GAO - Government Accountability Office

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

HCPCS - CMS's Common Procedure Coding System

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

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

HHS - United States Department of Health and Human Services

ICD-9-CM - International Classification of Disease, 9<sup>th</sup> Edition, Clinical Modification

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

Inmate - One 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.

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

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

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

MMIS - Medicaid Management Information System

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

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

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

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

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

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

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

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

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

Medically Necessary Service - A service or supply that is:

- Required to identify or treat an illness or injury and
- Prescribed or ordered by a physician and
- Consistent with the covered person's illness, injury or condition and in accordance with proper medical and surgical practices prevailing in the medical specialty or field of medicine at the time rendered and
- Required for reasons other than the convenience of the patient. The fact that a service is prescribed does not automatically define the service as medically necessary.

Member or SCHIP MCO Program Member or Program Member - An eligible child who voluntarily enrolls with a SCDHHS approved SCHIP Contractor.

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

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

Non-Covered Services - Services not covered under the Title XXI SC State SCHIP Plan.

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

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

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

Out-of-Plan Services - Services not included in the Contractor's Core Benefits.

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

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

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

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

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

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

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

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

Program - The method of provision of Title XXI services to South Carolina recipients as provided for in the Title XXI SC State SCHIP Plan and SCDHHS regulations.

Provider - Any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers services.

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

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

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

Referral Services - Health care services provided to members outside the Contractor's designated facilities or its subcontractors when ordered and approved by the Contractor, including, but not limited to out-of-plan services which are covered and reimbursed by the plan.

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

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

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

RHC - A South Carolina licensed rural health clinic is certified by the CMS and receives Public Health Services grants. An RHC provides a wide range of primary care and enhanced services in a medically underserved area.

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

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

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

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

SCDOI - South Carolina Department of Insurance

SCDHHS - South Carolina Department of Health and Human Services

SCDHHS Appeal Regulations - Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 and S.C. Code Ann. §§1-23-310 et seq. (2006, 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 comprehensive written commitment by a Medicaid agency, submitted under section 1902(a) of the Act, to administer or supervise the administration of a Medicaid program in accordance with Federal requirements.

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

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

Termination - The member's loss of eligibility and therefore automatic disenrollment from the Contractor's plan.

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

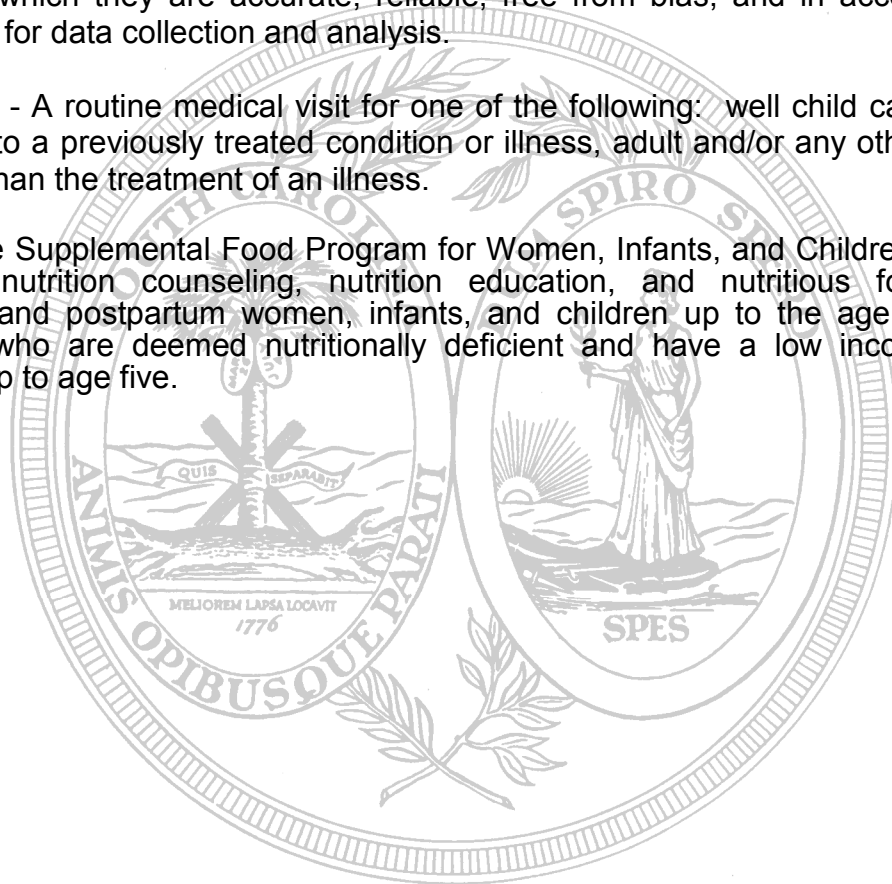


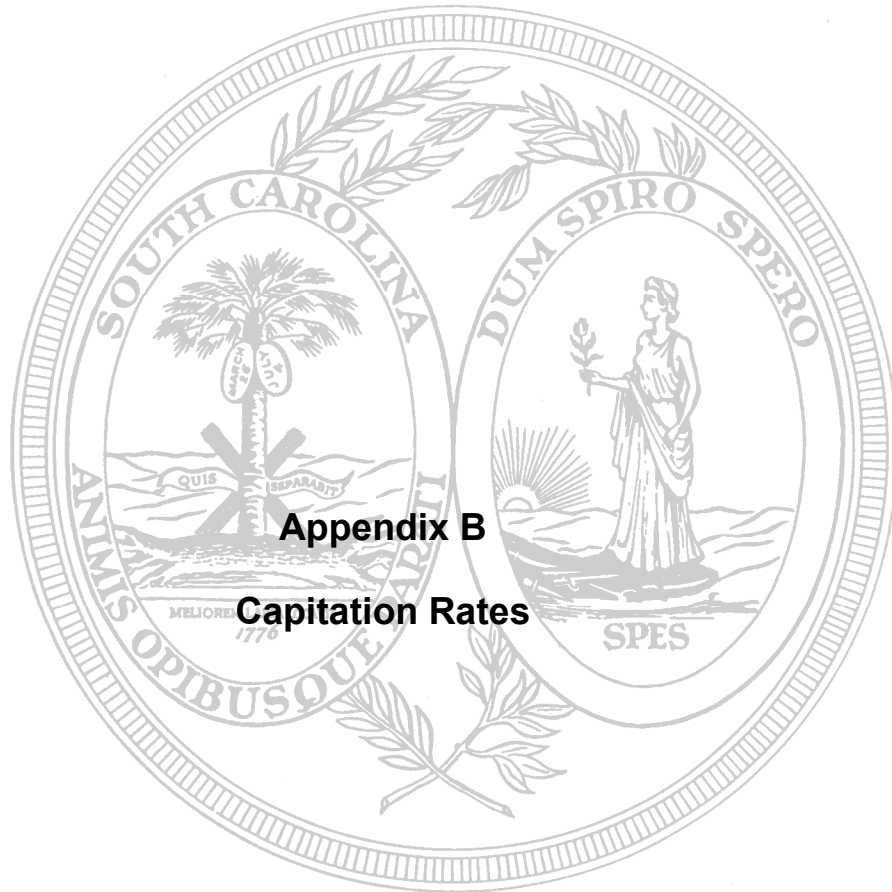
Urgent Care - Medical conditions that require attention within forty-eight (48) hours. If the condition is left untreated for 48 hours or more, it could develop into an emergency condition.

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

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

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





**Appendix B**  
**Capitation Rates**

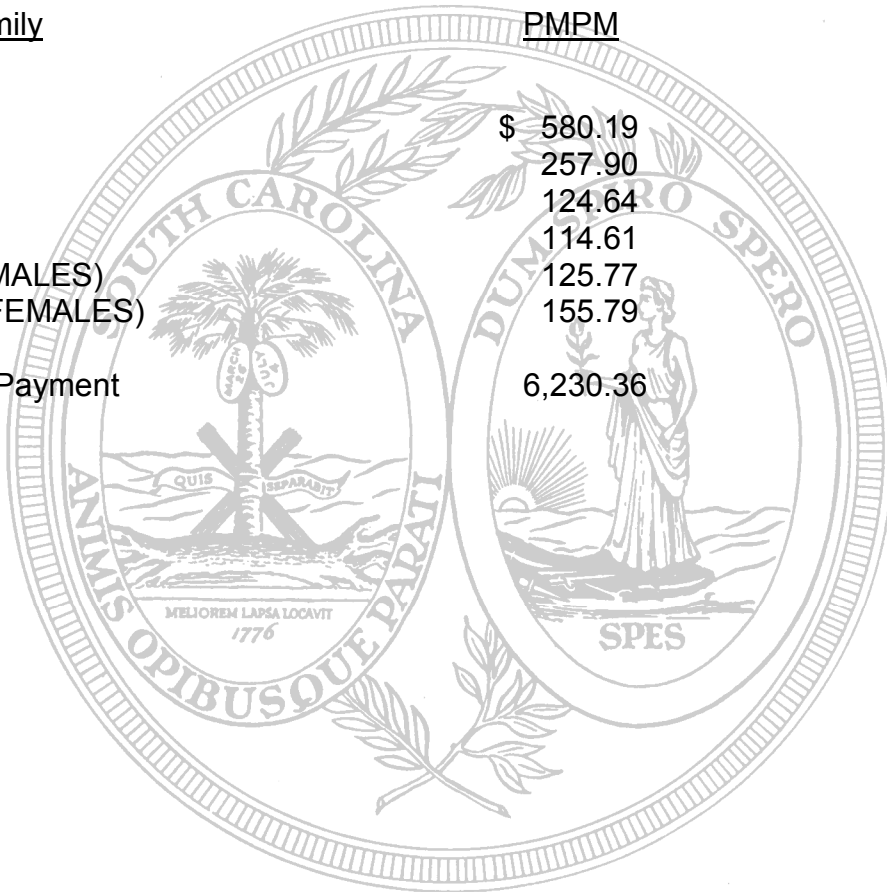
South Carolina  
 Department of Health and Human Services  
 Healthy Connections Kids Capitation Rates

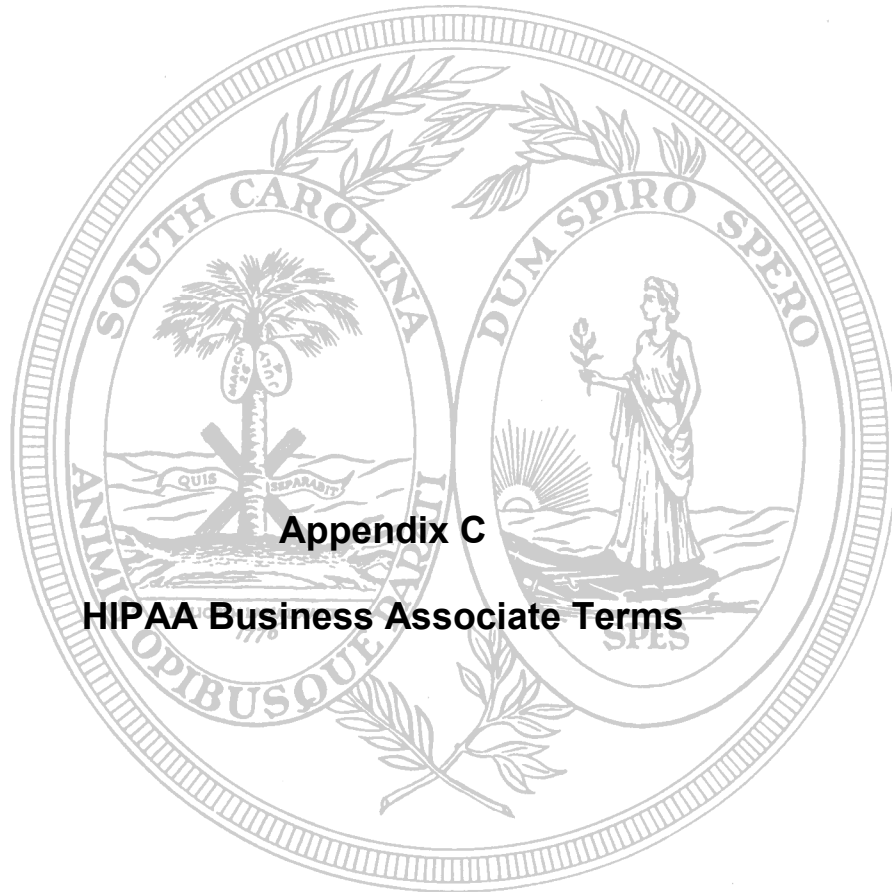
Rate Period: April 1, 2010 - March 31, 2011

Aid Category Family

PMPM

1-2 Months	\$ 580.19
3-12 Months	257.90
AGE 1 TO 6	124.64
AGE 7 TO 13	114.61
AGE 14 TO 18 (MALES)	125.77
AGE 14 TO 18 (FEMALES)	155.79
Maternity Kicker Payment	6,230.36





**Appendix C**  
**HIPAA Business Associate Terms**

## HIPAA BUSINESS ASSOCIATE

### A. Purpose

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

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

1. Business Associate means the same as "business associate" in 45 CFR §160.103.
2. Covered Entity means SCDHHS.
3. Designated Record Set means the same as "designated record set" in 45 CFR §164.501.
4. Individual means the same as "individual" in 45 CFR § 160.103 and includes a person who qualifies as a personal representative in accordance with 45 CFR §164.502(g).
5. Privacy Rule means the HIPAA Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 160 and Part 164, Subparts A and E).
6. Protected Health Information (PHI) means the same as the term protected health information in 45 CFR §160.103, limited to information received by Agency from Covered Entity.
7. Required By Law means the same as "required by law" in 45 CFR §164.103, and other law applicable to the PHI disclosed pursuant to the Contract.
8. Secretary means the Secretary of the Department of Health and Human Services or designee.
9. Security Standards shall mean the Security Standards at 45 C.F.R. Part 160 and Part 164, as may be amended.
10. Electronic PHI shall have the same meaning as the term "electronic protected health information" in 45 C.F.R. §160.103.
11. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system or its current meaning under 45 C.F.R. §164.304.

C. Business Associate Provisions

Business Associate agrees to:

1. Not use or disclose PHI other than as permitted or required by the Contract or as required by law.
2. Use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for in the Contract.
3. Mitigate to the extent practicable, any harmful effect known to Business Associate if it uses/discloses PHI in violation of the Contract.
4. Immediately report to Covered Entity any breaches in privacy or security that compromise PHI. Security and/or privacy breaches should be reported to:

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

The Report should include a detailed description of the breach and any measures that have been taken by the Business Associate to mitigate the breach.

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

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

5. Ensure that any agent/subcontractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Appendix.
6. If the Business Associate has PHI in a designated record set: (1) provide access at Covered Entity's request to PHI to Covered Entity or, as directed by Covered Entity, to an individual in order to meet the requirements under 45 CFR §164.524; (2) make any amendment(s) to PHI in a designated record set that Covered Entity directs or agrees to pursuant to 45 CFR §164.526.
7. Make its internal practices, books, records, and policies/procedures relating to the use/disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity, to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

8. Document Business Associate disclosures of PHI, other than disclosures back to Covered Entity, and related information as would be required for Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR §164.528.
9. Provide to Covered Entity or an individual, as designated by Covered Entity, information collected in accordance with Section C.8 of this Appendix, to permit Covered Entity to respond to a request for an accounting of PHI disclosures in accordance with 45 CFR §164.528.
10. Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as iPods, and MP3 and MP4 players), and personal organizers.
11. Otherwise, not re-disclose Covered Entity PHI except as permitted by applicable law.
12. Be liable to Covered Entity for any damages, penalties and/or fines assessed against Covered Entity should Covered Entity be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this section. Covered Entity is authorized to recoup any and all such damages, penalties and/or fines assessed against Covered Entity by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which Covered Entity maybe obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and Covered Entity, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

D. Permitted Uses and Disclosures by Business Associate

1. Except as limited in the Contract, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract, provided that such use would not violate the Privacy Rule if done by Covered Entity or Covered Entity's privacy practices. Unless otherwise permitted in this Appendix, in the Contract or required by law, Business Associate may not disclose/re-disclose PHI except to Covered Entity.
2. Except as limited in this Appendix, Business Associate may use/disclose PHI for internal management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide its services under the Contract.
3. Except as limited in this Appendix, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by 42 CFR §164.504(e)(2)(i)(B).
4. Business Associate may use PHI to report violations to appropriate Federal or State authorities as permitted by §164.502(j)(1).

E. Covered Entity Provisions

Covered Entity agrees to:

1. Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR §164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.
2. Notify Business Associate of any changes in, or revocation of, permission by individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.
3. Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.
4. Not request Business Associate to use/disclose PHI in any manner not permitted under the Privacy Rule if done by Covered Entity.

F. Term and Termination

1. The terms of this Appendix shall be effective immediately upon signing of the Contract and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.
2. Upon its knowledge of a material breach by Business Associate, Covered Entity shall either:
  - a. Allow Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; or
  - b. Immediately terminate the Contract if Business Associate has breached a material term of this Appendix and cure is not possible; or
  - c. If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

3. Effect of Termination

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



- b. If Business Associate determines that returning the PHI is infeasible, Business Associate shall notify Covered Entity of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, Business Associate shall extend the protections of this Appendix to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

G. Security Compliance

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

H. Miscellaneous

1. A reference in this Appendix to a section in the Privacy Rule means the section as in effect or as amended.
2. The Parties agree to amend this Appendix as necessary to comply with HIPAA and other applicable law.
3. The respective rights and obligations of Business Associate under Section F. 3. shall survive the termination of the Contract.
4. Any ambiguity in this Appendix shall be resolved to permit Covered Entity to comply with the Privacy Rule.