SCDHHS Applicant MCO Certification Process

The Centers for Medicare & Medicaid Services (CMS) has approved the South Carolina Department of Health and Human Services' (SCDHHS) State Plan Amendment (SPA SC-24-0026) regarding the limitation on the number of Medicaid managed care plans that can operate in the state. Effective November 2, 2024, the state will not be enrolling new managed care plans into the Healthy Connections Medicaid Program.

This change is intended to streamline the managed care delivery system and ensure that existing plans can continue to provide high-quality services to the state's Medicaid beneficiaries. In the event SCDHHS identifies a need for an additional managed care organization (MCO), interested parties will be required to complete the SCDHHS "MCO Certification Requirements - Applicant" document.

SCDHHS is driven by its mission to be boldly innovative in improving the health and quality of life for South Carolinians. This certification process invites MCOs to align with SCDHHS' mission and strategic plan, offering key opportunities for enhancement proposals to existing contract requirements and future amendments. The certification process is divided into 4 Gates comprised of 151 elements.

Gate 1: Needs Assessment

- Evaluates the applicant's eligibility and intent to participate.
- Requires formal documentation from SCDHHS in alignment with SPA SC-24- 0026.
- If the applicant does not meet this basic requirement, they cannot proceed.

Gate 2: Minimum Qualifications

- Ensures the applicant meets fundamental industry standards.
- Requires NCQA accreditation, compliance reports, and evidence of network adequacy.
- Failure to meet these minimum qualifications results in elimination.

Gate 3: Experience Analysis

- Assesses the applicant's historical performance in healthcare services.
- Requires submission of performance scores, audit results, and healthcare outcome data.
- Applicants must demonstrate successful past performance to move forward.

Gate 4: Standards and Elements

- The most detailed evaluation, covering 140 elements across areas like administration, finance, provider networks, and quality management.
- Applicants must provide contracts, financial statements, and compliance reports to demonstrate their ability to operate effectively.
- Failure to meet the required standards results in disqualification.

Gate 1: Needs Assessment		
Element Detail	**Applicant Detail**	**Evaluation Criteria**
1.1	SCDHHS limits the number of Medicaid MCOs via a 1932(a) state plan amendment to no less than two and no more than four. If SCDHHS currently contracts with the maximum four plans, then SCDHHS will not accept applications from prospective MCOs. If SCDHHS is contracted with fewer than four MCOs and, in its sole discretion, determines that contracting with an additional MCO would serve the best interest of the State, then Applicants will proceed sequentially through each of the certification standards in Gates 2 through 4 described herein. Federal Medicaid rules require that states have at least two managed care plans, and there are limited circumstances in which a state can have fewer than two plans. There are no federal maximums on plans, and states have discretion in the number of plans with which they contract. SCDHHS's minimum and maximum number of MCOs preserve beneficiary choice while also promoting key interests such as the financial viability of MCOs and reductions in provider administrative burden.	Formal invitation letter from SCDHHS

Gate 2: Minimum Qualifications		
Element Detail	**Applicant Detail**	**Evaluation Criteria**
2.1	The applicant must average its most recent NCQA Star Rating for all their Medicaid HMO plan type contracts across states.	Applicants must submit the overall Medicaid Star rating for the most recent year in each state where they operate a Medicaid plan and the average overall rating of all states. The overall average must be 3.5 or above.
2.2	The applicant must be NCQA Health Plan and Health Equity accredited for the Medicaid HMO plan type in all other states where they offer a Medicaid plan and have no ongoing NCQA performance improvement plan (PIP) or corrective action plan (CAP) in those states.	Applicants must be NCQA Health Plan and Health Equity accredited for the Medicaid HMO plan type in all other states where they offer a Medicaid plan. The accreditation status must be full, not one-year, provisional, or denied as defined by NCQA. The MCOs must have no ongoing NCQA performance improvement plan PIP or CAP in those states.

2.3	The applicant must submit a summary of non-compliance which includes all liquidated damages, fines, and penalties; sanctions and premium withholds; corrective action plans; and litigation within the last three complete contract years and any contract or agreement cancellations in the last five years. The summary must include all state contracts serving Medicaid beneficiaries.	Applicants must provide a report that includes the following information for the most recent three complete contract years for Medicaid contracts in all states for which it served Medicaid beneficiaries: - Liquidated damages, fines, and penalties – Disclose all monetary amounts charged due to non-compliance. Sanctions and withholds – Disclose all non-monetary penalties charged due to non-compliance. - Corrective Action Plans (CAPs) – Disclose all written plans of action to correct cited deficiencies. - Litigation – Disclose any open, pending, or settled litigation related to the contract. Applicants must provide a report that includes the following information for the most recent five complete contract years for Medicaid contracts in all states for which it served Medicaid beneficiaries: - Contract Terminations – Disclose whether the MCO voluntarily terminated a contract, in whole or in part; had a contract partially or fully terminated before the contract end date (with or without cause); withdrew from a contracted service area of a managed care contract; or experienced a reduction of enrollment levels of a contract. If a contract or agreement was canceled or terminated either voluntarily or involuntarily, the MCO must provide details on the state agency's allegations, the MCO's position relevant to the allegations, and the final resolution of the cancellation or termination.
2.4	The applicant must provide evidence of the ability to develop a statewide provider network, including SCDHHS-approved letters of interest/intent and pending or executed contracts with healthcare providers across all relevant provider types, as defined in the Managed Care Organizations Policy and Procedure Guide for Managed Care Organizations. For geographic areas lacking providers sufficient in number, mix, and geographic distribution to meet the needs of the SCDHHS-projected number of members, SCDHHS, at its sole discretion, may waive requirements.	Applicants must demonstrate an adherent network by submitting a completed Provider Network Report as defined in Managed Care Report Companion Guide. Applicants may include providers with which they do not have a fully executed contract if the applicant has a signed letter of agreement or letter of intent to contract that meets SCDHHS standards. SCDHHS will conduct a network submission assessment and generate a Failure Severity Index Report to identify network adequacy failures for a provider specialty and county. The Failure Severity Index Report produces an overall weighted score in the areas of provider specialty, member eligibility category and county, member threshold mileage, and time. The weighted results are then categorized into four severity categories of low, mid-low, mid-high, and high for the MCO's final failure severity ranking.
Gate 3: Experience Analysis		
Element Detail	**Applicant Detail**	**Evaluation Criteria**

3.1	The applicant must provide scores, feedback, and other information provided by NCQA to the applicant as part of its Health Plan and Health Equity accreditation. These materials are designed to assist SCDHHS in further understand MCO qualitative and quantitive performance during the accreditation process.	The applicants and MCOs must submit the results of the most recent NCQA and HE accreditation or accreditation renewal process. For accreditation or distinction elements that were scored Partially Met or Not Met, failed to meet a must-pass requirement, or for which NCQA required a PIP or CAP, the MCO must provide documentation that shows it has closed any gaps in Partially Met or Not Met elements to meet 100% score, most recent accreditation onsite results, and remediated must pass standards, PIPs, and CAPs.
3.2	The Applicant must submit a report identifying any action plan, corrective action plan, or other required step or activity issued by the External Quality Review Organization in an External Quality Review (EQR) in one or more of the three comparison states. Additionally, Applicants should provide evidence to show improvement over time or that demonstrate full resolution. This requirement is intended to assist SCDHHS in further understanding MCO performance by reviewing EQR technical reports for a set of comparison states. This review will focus on External Quality Review elements that indicate the MCO did not meet a certain requirement, performance fell below a certain threshold, or that additional actions needed to be taken to achieve compliance.	The applicant and MCOs must demonstrate that, in the the relevant state(s), any EQR results indicated the need for an action plan, corrective action plan, or other required action show improvement over the three-year period or demonstrated full resolution.
3.3	Applicants must provide the total number of HACs and PPCs for their members compared to the contract MCOs established goal and evidence of payment restriction to hospitals for three comparison states for the last three complete contract years. Existing MCOs must demonstrate compliance with HAC and PPC reduction goals and payment restrictions as detailed in the contract.	Applicants must demonstrate that reported Hospital Aquired Conditions (HAC) and Potential Preventable Complications (PPC) cases for their members meet the contract goal and that payment restrictions to hospitals were enacted in comparison states for the most recent three complete contract years. Applicants pass this standard if they meet the state contract standard or, at SCDHHS's discretion, show significant progress in meeting the contractual requirements. MCOs pass this standard if they maintain a sufficiently low number of HACs and PPCs or show improvement in decreasing the numbers.
3.4	Applicants must provide the percentage of members assigned to PCMH for their primary care provider in for three comparison states in which there is a state contract requirement for promotion of or other recognition of PCMHs. Applicants must disclose whether they were compliant with the contractual PCMH standard for each of the last three complete contract years and, if not, the gap between the standard and the Applicant's performance. Existing MCOs must report the percentage of South Carolina members assigned to an NCQA-certified PCMH for their primary care provider for each year of the contract.	Applicants pass this standard if they demonstrate compliance with the comparison state's PCMH contract standard or, at SCDHHS's discretion, show significant progress in meeting the contractual requirement. MCO submissions will be reviewed to ensure the percentage of an MCO's members served in NCQA-certified PCMHs has increased during the contract period.
3.5	Applicants must provide a summary of performance on network adequacy standards for three comparison states for the most recent three complete contract years.SCDHHS will specify the format in which the applicant must submit the information, including how to calculate the compliance percentage and how to factor in state-granted waivers of standards.	Applicants must demonstrate at least 95% compliance on contractual network standards, including, as applicable, time and distance standards, provider-to-enrollee ratios, and provider availability measures (e.g., appointment wait times or acceptance of new patients). State-granted waivers of standards can be factored into the compliance percentage. MCOs must demonstrate an adherent network by submitting a completed Provider Network Report as defined in Managed Care Report Companion Guide.

3.6	Applicants must provide an APM performance report, in the format specified by SCDHHS, that demonstrates compliance with state contract standards for APMs in three comparison states for the most recent complete contract year.	Applicants must show 100% compliance with contract standards pertaining to percentage of total Medicaid payments under APM agreements, for the comparison states in the past year. MCOs must be demonstrate consistent compliance with the SCDHHS contract standards for APMs.
3.7	Applicants must provide evidence for three comparison states that demonstrate at least 95% of grievances and appeals were resolved within the contract timeframes for the most recent three complete contract years.	Applicants must show that 95% of appeals and grievances were resolved within the contract timeframes in the comparison states. MCOs must demonstrate compliance with SCDHHS contractual standards for appeal and grievance resolution and evidence of a robust quality improvement system that ensures regular review of complaints and grievances for trends, root cause analysis, and implementation of improvement plans.
3.8	Applicant must provide claims submission reports for three comparison states for the most recent three complete contract years. The reports must demonstrate the percent compliance with the payment accuracy standards defined in the respective state contract.	Applicants must show at least 95% compliance with the contract standards for claims payment timeliness and accuracy in comparison states for the past three years. MCOs must show compliance with the SCDHHS contract standards for claims processing.
3.9	Applicants must submit encounter data timeliness, accuracy, and completeness reports for three comparison states for the most recent three complete contract years. The reports must demonstrate the percentage of compliance with the standards defined in the respective state contract.	Applicants must show at least 95% compliance with the contract standards for encounter data timeliness, accuracy, and completeness in the comparison states as required in Appendix A for the most recent three complete contract years. MCOs must show compliance with the SCDHHS contract standards for encounter data.
3.10.	Applicants must submit community reinvestment plans for all comparison states that have a CRP requirement and demonstrate compliance with the respective state contract requirements. The applicant must submit a draft South Carolina community reinvestment plan that specifies the methodology used to develop the targeted investments and the expected health outcomes from the investment. The MCO must commit to investing a minimum of one percent of profits in the first two contract years and an additional one percent each subsequent year until the investment reaches five percent of profits.	Applicants must submit a community reinvestment plan that specifies the methodology used to develop the targeted investments and the expected health outcomes from the investment. The MCO must commit to investing a minimum of one percent of profits in the first two contract years and an additional one percent each subsequent year until the investment reaches five percent of profits.

Gate 4: Contract Standards and Elements

Element Detail	Applicant Detail	Evaluation Criteria
4.1	Applicants must complete required South Carolina Department of Insurance (SCDOI) Licensure and provide written notification to the SDCHHS Bureau of Managed Care in the manner defined is the SCDHHS MCO Process and Procedure Manual. Applicant must present copy Certificate of Authority by the South Carolina Department of Insurance.	Filing only

4.2	Provide all P&Ps, SOPs, and internal reporting samples regarding general care management and coordination requirements, including initial screenings and protocols.	The Department will review MCO P&Ps, SOPs, and methodologies to ensure adherence to all requirements in MCO Con 5.1. MCO must provide a narrative detailing their approach to conducting an initial screen of each Enrollee's needs.
4.3	Provide detailed description of the Contractor's Complex Case Management program.	The Department will review to ensure coordination activities conform to the requirements and industry standards stipulated in the NCQA rquirements for Complex Case Management and other requirements outlined in MCO Con 5.1.
4.4	Provide specific, detailed program description for the person centered case management approach the Applicant will provide for special populations outlined in the MCO contract, including: Members identified as having a Serious Mental Illness or Members under the age of 18 within th Foster Care System. Program description must describe methods that include quarterly in-person visitation and monthly telephonic case management.	The Department will review the program description to ensure special populations are incorporated into a person-centered Care Management Plan that guarantees the most appropriate level of care.
4.5	Provide a Care Coordination and Case Management Program Description to include: •Procedures for assigning a case manager to enrollees •Procedures for documenting an enrollee's or the enrollee's authorized representative's rejection of case management services •Responsibilities of the case manager, including participation in all scheduled and any ad hoc meeting(s) for assigned enrollees, i.e. Interagency Staffing or PRTF Treatment Team Meetings •How the MCO shall implement and monitor the case management program and standards outlined in this Contract •Methodology for assigning and monitoring case management caseloads and emergency preparedness plans as well as average case assignments per case manager •Procedures for resolving conflict or disagreement in the care planning process, including guidelines for all participants •Evaluation of the MCO's case management program from the previous year, highlighting lessons learned and strategies for improvement •Required elements of the case management program and responsibilities of the case manager/case manager supervisor; a workflow and/or organizational structure of the plan's case management model.	The Department will review the program description to ensure it is based on sound evidence and conforms to the requirements and industry standards stipulated in the NCQA requirements for Complex Case Management and by the Standards of Practice of Case Management released by the Case Management Society of America. Additionally, the description should conform with all applicable provisions within MCO Contract sections 5.1, 5.2, 5.3, 5.4, and 5.5

4.6	Provide the applicant's member risk stratification methodology and all applicable P&Ps for stratifying members based on risk.	The Department will review materials to ensure conformity with MCO Con 5.2, including descriptions of the following: • Member risk stratification methodology. • Member risk stratification categories. • Member risk stratification for special populations.
4.7	Provide detailed care management activity plans stratified by member risk category. Please specify which risk stratification categories or populations will receive face-to-face care management. Provide reports demonstrating evidence of both.	The Department will review care management activity plans to ensure alignment with MCO Con 5.3, including the specific requirements for each risk stratification category.
4.8	Provide all P&Ps and associated reports for continuity of care of care activities, including coordination of services for physical and Behavioral Health Services. The P&P should describe processes for service need determination, service delivery coordination, and referral and scheduling assistance for specialty health care.	The Department will review applicable P&Ps to ensure compliance with MCO Con 5.1, 5.5, and 5.6, and consistency with 42 CFR § 438.208. This includes, but is not limited to: • Ensuring appropriate referrals, monitoring, and follow-up to Providers within the network, • Ensuring appropriate linkage and interaction with Providers outside the network. • Processes for effective interactions between Medicaid Managed Care Members, in- network and out-of-network Providers and identification and resolution of problems if those interactions are not effective or do not occur.
4.9	Provide the applicant's Transition Plan and applicable P&Ps describing how the MCO will meet transition of care requirements. The Transition Plan must include a detailed description of the process for transitioning Medicaid Managed Care Members between various healthcare settings or from out- of-network Providers to the applicant's Provider network to ensure optimal Continuity of Care.	The Department will review the Transition Plan and applicable P&Ps to ensure compliance with MCO Con 5.6 and 8.7.2, and consistency with 42 CFR § 438.62(b)(1) - (2)). The Transition Plan should include the following elements: • Coordination of hospital/institutional discharge panning and post discharge care. • Assistance to schedule follow-up appointments. • Collaborating with the hospital/institutional discharge planner/coordinator to implement the discharge plan. • Facilitating communication with community service providers and coordination of care after emergency department visits.
4.10.	Provide all P&Ps and SOPs describing the process for completion of health risk assessments for all enrollees (including any prioritization hierarchy) and how the MCO will implement, track, and report on the completion of health risk assessments for enrollees who are pregnant, have mental illness, diabetes, or asthma.	The Department will review the P&Ps and SOPs to ensure compliance with MCO Con 5.1.2, 5.14, and 5.2.3. Additionally, the Department will review processes to ensure the completion of health risk assessments for enrollees who are pregnant, have mental illness, diabetes, or asthma.
4.11.	Provide all P&Ps describing the process for the Care Coordination and Case Management activities for Members enrolled in Foster Care. Additionally, the applicant should submit a Care Coordination and Case Management Program Description in which Foster Care-specific information is separately identifiable.	The Department will review P&Ps and the program description to ensure compliance with MCO Con 4.2.27, 4.3.7.54, and 5.8. The program description must include content specific to Members enrolled in Foster Care, including clear recognition of this population's particularized healthcare needs.
4.12.	Provide copy of provider boilerplate contracts for SCDHHS prior approval.	Review of contracts to ensure all contracts include, verbatim, the Minimum Subcontractor Provisions (MSPs) contained in Appendix D of the SCDHHHS MCO Contract.

4.13.	Provide all P&Ps and SOPs that demonstrate ability to meet general contractor administrative requirements.	P&P's will be reviewed to ensure adequate processes and controls are in place to ensure compliance with contractual obligations.
4.14.	Provide P&Ps that demonstrate the ability to meet contractual staffing requirements and associated reporting requirements. Additionally, provide a staffing plan that includes the following: • Full-time equivalent (FTE) allocation of staff dedicated to the Applicant's Medicaid program. Note position locations if not in South Carolina. Document the portion of staff that will be new hires versus intra-organization transfers. Specify those staff that are dedicated to Applicant plan only. • Identification of vacant positions. • Staff licensure/credentials, where applicable. • A hiring plan that includes deadlines for hiring to fully staff the program.	Staffing will be assessed to ensure compliance with MCO Con 2.2, including that all Key Personnel positions are filled and that the applicant employs sufficient staff to effectively manage operations.
4.15.	Provide P&P's and a narrative summary describing the MCO's internal training plan for the preparation of the new contract for all employees. Include the process and timeframes for completing all associated curriculum and how staff participation is determined. Also include all subcontractor training plans for all departments.	P&P's will be reviewed to ensure compliance with MCO Con 3.3, including descriptions of processes for training towards operations, compliance, and South Carolina state specific provisions.
4.16.	Provide P&P's and a draft of the Provider training plan that will be provided to network Providers. Include the process and timeframes for conducting and completing education to the in network Providers prior to Applicant's estimated Go Live. Include any Provider materials that would be utilized to perform initial training of the network.	P&P's will be reviewed to ensure adequate processes and controls are in place to ensure compliance with MCO Con 2.3. The Provider training plan and provider education materials shall be reviewed for completeness and adherence to the contract.
4.17.	Provide P&P's and a narrative summary describing the MCO's training plan for Subcontractors. The summary should include evidence that Subcontractors are aware of written policies and procedures that will be required for them to maintain related to Member Rights and Responsibilities, Fraud Waste and Abuse, and any other required elements.	P&P's will be reviewed to ensure adequate processes and controls are in place to ensure compliance with MCO Con 2.3. The narrative shall be reviewed for completeness, adherence to the contract, and the inclusion of necessary elements listed.
4.18.	Provide all applicable P&Ps related to the use of and delegation of authority to Subcontractors, including: • Processes for ensuring adherence to applicable contractor requirements. • Ensuring subcontractors meet specific accreditation standards. • Methods for monitoring the Subcontractor's performance on an ongoing basis. Provide a narrative summary describing the process for updating subcontractor agreements and providing updates on the new contract implementation.	P&P's will be reviewed to ensure adequate processes and controls are in place to ensure compliance with all requirements in the MCO Contract, including sections 2.5., 2.6, and 6.6.
4.19.	For all executed subcontracts, submit all copies of executed contracts and a companion tool for each submission.	Subcontracts will be reviewed for adherence to the requirements outlined in the MCO Contract, including the Minimum Subcontractor Provisions and all required elements.

4.20.	Provide a baselined go-live project schedule for the contract. The project schedule should include detailed tasks and staff assigned to such, milestones, percent complete, and relevant dates including start and end dates (actual), revised dates (if changes) and planned end dates. Include closed, open and in-flight tasks.	The project plan will be thoroughly assessed to verify that all essential steps are included, that it is realisics, and that the timing of activities aligns with the overall schedule established by the Department. Particular attention will be paid to contingency planning and testing phases.
4.21.	Provide a narrative summary describing how the Applicant tracks go-live project risks and project issues, including a list of issues and risks related to the contract. The narrative should include a template of the risk log/register that is used to document risks. Provide a copy of the three most recent project status reports related to the new contract.	The narrative and template will be evaluated for the presence and adequacy of contingency measures to address potential risks, issues, or delays that may arise during the project. This should include backup plans, risk mitigation strategies, and resource allocation for unexpected circumstances.
4.22.	Provide a list of all internal management reports related to the implementation of the new contract including a description of how they are used, the departments that use them, and a status report reflecting one of the following statuses: • Tested and in production • Developed, testing in progress • Development underway • Scoped (analysis complete), pending development • Not started For each report, indicate the anticipated production-ready date.	Reports shall be reviewed for thoroughness, alignment with common practice, and completeness. Furthermore, the development status of each report – based on provided categories and anticipated production-ready dates will be reviewed for inconsistencies and potential delays. The applicant should ensure effective communication and resource allocation.
4.23.	Provide P&Ps and SOPs related to provider enrollment and credentialing. Provide a written description of the Credentialing program, including the delegation of Credentialing activities, if appropriate.	P&Ps will be reviewed to ensure compliance with MCO Con 2.7. The Credentialing program description must comply with 42 CFR § 438.12 and 438.230.
4.24.	Provide a flowchart depicting the process the plan will follow to ensure providers are fully onboarded within 60 days. Include a P&P for how the plan will determine if a provider application is complete. Include all milestones for ensuring each step of the onboarding process is complete to meet the 60 day timeframe.	The onboarding process and flowchart shall be analyzed for clarity and completeness, ensuring it covers all critical milestones within the 60-day timeframe, including: reviewing, approving, and processing approved applicants to its Provider files in its Claims processing system or denying the application and assuring that the Provider is not used by the Contractor. The P&P will be reviewed for determining application completeness and assess the timelines for each milestone. The P&P should include any potential communication channels and resource allocation to address potential issues and promote timely onboarding.
4.25.	Provide all P&Ps for ensuring that the provision of services, in terms of frequency, duration, and scope meet the requirements outlined in the current Healthy Connections Medicaid Coverage Policies, the State Plan, federal and state statutes, rules, and regulations.	The Department will review P&Ps to ensure compliance with all items in MCO Con 4.1 and 4.2 and shall be reviewed for completeness for coverage and benefits.

4.26.	Provide all P&Ps related to Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Provide detail about the following: • Outreach and communication strategies regarding enrollee education, • The process for referrals for follow-up of any problems/conditions identified, • Assurance of a firm understanding by all impacted departments, • The monitoring approach to ensure compliance with EPSDT requirements, and • A transparency plan for external stakeholders.	P&Ps will be reviewed to ensure compliance wtih all items in MCO Contract Section 4.1 and Section 4.2 and shall be reviewed for completeness for coverage and benefits. Additional materials will be reviewed to ensure compliance with applicable federal regulations, and ensure applicant maintains a strong approach, including performance metrics, service delivery practices, and oversight practices, for the delivery of high-quality care.
4.27.	Provide P&Ps and SOPs supporting monitoring capabilities to ensure adherence to the Department's Medicaid Preferred Drug List.	The Department will review P&Ps and SOPs to ensure compliance with MCO Contract Section 4.1 and Section 4.2, including completeness for coverage and benefits.
4.28.	Provide all P&Ps for ensuring that the Applicant's Prior Authorization criteria and step therapy protocols for Medicaid-covered Prescribed Drugs not on the Department Medicaid PDL are in compliance with sections 1902, 1903, and 1927 of the Social Security Act and 42 CFR 438.3	The Department will review P&Ps to ensure compliance with all items in MCO Contract Section 4.1 and Section 4.2, including completeness for coverage and benefits. Additionally, all Prior Authorization and step therapy protocols must be in compliance with sections 1902, 1903, and 1927 of the Social Security Act and 42 CFR 438.3
4.29.	Provide outline of Additional Services the applicant seeks to offer, including how the services will be assessed on an annual basis for enrollee engagement. Provide associated enrolee materials for Department approval. Include all P&Ps describing applicants processes for appropriate notifications, submission of requisite research and analyses, and approvals.	P&Ps will be reviewed to ensure compliance with MCO Con section 4.8. P&Ps should include a description of how the services will be assessed.
4.30.	Provide a description of the Member Incentives the applicant seeks to offer, including a description of the reporting to be provided to the Department to assess the impact of the incentive. Provide P&Ps outlining the process for implementing and overseeing Member Incentives.	Descriptions will be reviewed to ensure the Member Incentive can be assessed for positive impact. P&Ps will be reviewed to ensure compliance with MCO Con section 4.8.
4.31.	Provide P&Ps regarding excluded services. The P&Ps shall the describe method of communicating to and educating members on how to access these services and the role that the MCO plays in assisting with the coordination and scheduling of such services.	P&Ps and member educational materials will be reviewed to ensure compliance with all items in MCO Con Section 4.4 and Managed Care Process and Procedure Manual section 4.4.
4.32.	Provide detailed information regarding the applicant's process for making Medical Necessity determinations, inclusive of a process flow and monitoring plan. Provide all applicable P&Ps describing how the applicant will provide medically necessary and evidence-based appropriate care to Members, including how the Applicant will determine Medical Necessity.	The process flow and monitoring plan shall be reviewed to ensure sufficient controls and oversight exist. P&Ps must address all items in MCO Contract Section 4.5 and shall be reviewed for completeness for coverage and how determinations are made. The process flow and monitoring plan shall be reviewed to ensure that steps are being taken to ensure services, procedures, or treatment is appropriate, necessary, and covered. Additionally, the monitoring plan should ensure the consistent and appropriate application of Medical Necessity.

4.33.	Provide P&Ps and SOPs regarding out-of-network coverage	The Department will review P&Ps and SOPs to ensure compliance with MCO Contract Section 4.6, including applicants ability to provide or arrange for out-of-network coverage of Core benefits in applicable situations.
4.34.	Provide P&Ps and SOPs regarding Second Opinions.	The Department will review P&Ps and SOPs to ensure compliance with MCO Contract Section 4.7.
4.35.	Provide P&Ps and SOPs regarding member moral and religious objection.	The Department will review P&Ps and SOPs to ensure compliance with MCO Con Section 4.9, including required information, noticing, and processes.
4.36.	Provide narrative overview to ensure specific core benefits and service requirements are met. The narrative shall explicitly describe the following specific core benefits: • Abortions • Ambulance transportation • Ancillary medical services • Audiological services • Autism Spectrum services • Behavioral Health services • Chiropractic services • Communicable disease services • Disease management • Durable Medical Equipment • Early and Periodic Screening, Diagnosis, and Treatment • Emergency and post stabilization services • Family Planning Services • Home health services • Hysterectomies • Independent laboratory and X-ray services • Inpatient hospital services • Institutional long-term care facilities/nursing facilities • Maternity services • Outpatient services • Physician services • Pharmcy/prescription drugs Provide P&Ps and SOPs regarding the provision of specific core benefits.	The Department will evaluate the narrative, P&Ps, and SOPs to ensure compliance with MCO Con 4.2, incuding provision of all required services and an understanding of all associated requirements.

4.37.	Provide diagrams and flowchart of the applicants management information system, depicting how data flows through each component and supports the data exchange requirements with the Department. Provide a specific diagram depicting the end-to-end claims and encounter processes from receipt of claim through adjudication and reporting. Provide a narrative summary describing each of software components of the management information system, including components to collect or support the following: • Member data • Eligibility and enrollment data • Provider data • Claims data • Prior authorizations • Care management • Encounter data, including pharmacy encounter data • Billing • Case management The Department may request demonstrations of the applicant's management information system.	The Department will review the diagrams and flow chart for completeness and clarity to ensure all relevant management information systems software are present and that required data exchanges are suported. The flowchart and description should thoroughly illustrate the information systems' interfaces, particularly the eligibility, enrollment, claims , and encounter processes. The Department will review the narrative summary to ensure that it demonstrates compliance with MCO Con 14, inclduing clear explanations of the role of each software component, an overview of its functionality, and a description of any differentiating features. Sufficient context should be provided for a comprehensive understanding of the systems in place.
4.38.	Provide a narrative summary describing the most recent information systems software version numbers, including implementation date and who has ownership of the programming code, vendor or Applicant. Include the next planned upgrades to each information system including the next version number, description of enhancements, and planned implementation date.	The Department will review the narrative to ensure software systems are regularly updated.
4.39.	Provide a narrative summary describing the Applicant's master data management, data management, and data quality tools and processes to ensure that all data is accurate, complete, and truthful. The Department may request demonsrations of the Applicant's system and processes to ensure high quality data.	The Department will review the narrative to ensure compliance with MCO Con 14 and 42 CFR § 438.606.
4.40.	Provide the Applicant’s System Manuals, or other relevant documentation, that describe all manual and automated system procedures for its information management processes and information systems.	The documentation shall be reviewed for completeness, accuracy, detail, and clarity around automated processes as well as controls and contingencies around those processes.
4.41.	Provide all P&Ps describing processes for ensuring source to target data quality (e.g., claims payment to data warehouse and financial systems). Include a description of the processes, including quality assurance testing, as well as report examples, demonstrating the ability to tie source data to reporting.	The Department will review P&Ps to ensure compliancew with MCO Con 14, including that appropriate data quality processes are in place. Report examples shall be reviewed for completeness and inclusion of necessary data elements.

4.42.	Provide a narrative summary describing plans for addressing updates to information systems, including Department-directed modifications, and business areas related to code set updates such as procedure codes, diagnosis codes, etc. Include timelines for testing and implementation for both standard updates and ad-hoc or directive updates.	The Department will evaluate the plan(s) to ensure adequate systems management and controls of updates are in place and for capabilities set forth in the MCO contract Section 14.
4.43.	Provide all P&Ps for the Applicant's process for ensuring its system is updated on a daily basis with the enrollee information files including the files sent from the Department and the roster report sent from the Department's enrollment broker. Also include all P&Ps relating to the Applicant's process for ensuring its subcontractors receive daily enrollee information from the Applicant and update their enrollee information systems daily.	The Department will review P&Ps to ensure compliance with MCO Con Section 3 and 14 ensuring timely processing.
4.44.	Provide all P&Ps for information systems backups and disaster planning, including timing of bringing systems back online. Include a narrative summary of the date and results from last recovery testing.	The Department will review P&P's to ensure they address contingency and disaster planning including detailing the applicants testing processes and frequency, as well as timing expectations to minimize any potential service disruptions.
4.45.	Submit for Department approval the business continuity/disaster recovery (BC/DR) plan.	The Department will review the BC/DR plan to ensure the MCO has taken the appropriate risk level assessment, impact analysis, developed response procedures, communications plan and conducted adequate staff training.
4.46.	Provide a narrative summary describing the Applicant's process of and capability to submit encounter data using HIPAA-compliant and proprietary formats.	The Department will review the narrative summary to ensure the MCO Encounter elements such as HIPAA compliance, data accuracy, data formats, provider onboarding, data transmissions, data validation, performance metrics, and error handling are adequately controlled.
4.47.	Provide all P&Ps used in the oversight process for ensuring all Encounter data is collected from subcontractors and submitted to the Department. Provide examples of the reports used to ensure that the encounter data submitted is complete, accurate, and timely.	The Department will review P&Ps to ensure compliance with all items in MCO Con Section 14, including ensuring timely Encounter processing and submissions.
4.48.	Provide all P&Ps for the Applicant's process to reconcile Encounter rejections and resubmit within thirty (30) days.	The Department will review P&Ps to ensure compliance with all items in MCO Con Section 14, including ensuring timely Encounter processing, submissions, and resubmissions.
4.49.	Provide all P&Ps for the Applicant's process for ensuring its system is reconciled on a monthly basis with enrollment payment reconciliation information files sent from the Department	The Department will review P&Ps to ensure compliance with MCO Con Section 14, including accurate reporting and reconciliation of Encounter submissions, as well as compliance with the requirement to submit quarterly Encounter Quality Initiative reports.
4.50.	Provide all P&Ps describing the capabilities for receiving and sending data using electronic data interchange (EDI) formats, including descriptions of the HIPAA required formats currently in use. Identify steps required for new providers to begin sending/receiving EDI files to the Applicant.	The Department will review P&Ps to ensure compliance with MCO Con Section 14, including the use of HIPAA-mandated EDI transaction formats and describing processes for Providers to send/receive data using EDI transaction formats.
4.51.	Provide the implementation/companion guide for trading partners to establish EDI connectivity with the Applicant for both batch and real-time transactions.	The Department will review the guide for clarity and completeness.
4.52.	Complete required system onboarding activities, including trading partner configuration. Submit system integration test plan for review and acceptance.	The Department will monitor onboarding activities to ensure alignment with the project plan. The Department will review the system integration test plan for alignment with industry standards.

4.53.	Provide all P&Ps for the Applicant’s process to validate the successful loading of encounter files by the Department. Include how the Applicant is able to identify success and failure of submission, and in the event of failure, information that provides the reason.	The Department will review to ensure compliance with MCO Con Section 14, including processes for receiving and reviewing response files, correcting submissions, and documenting and quantifying rejected encounters.
4.54.	Provide all P&Ps, methodologies, and monitoring activities associated with payments made for members served by the State of South Carolina’s Early Intervention System under Part C of the Individuals with Disabilities Education Act (IDEA Part C) referred to as BabyNet.	MCO shall submit coordination of benefits (COB) claims processing P&Ps, SOPs, and internal reports/controls that ensure accurate payment oversight for members with secondary coverage served by the BabyNet program
4.55.	Provide all P&Ps, SOPs, and internal reports related to Applicant's responsibilities related to the State of South Carolina’s Early Intervention System under Part C of the Individuals with Disabilities Education Act (IDEA Part C) referred to as BabyNet, inclding accepting all BabyNet approved Individualized Family Service Plan services in a format specifie by the Department.	The Department will review P&Ps, SOPs, and internal reports for members served by the BabyNet program, including how the Applicant will appropriately authorize services as specified in MCO Con Appendix E.
4.56.	Applicants shall provide written disclosure and supporting evidence of the following: •Business plan •Ownership Disclosure Form •Board member names and qualifications •Officer names and qualifications	Applicants must submit a an executive summary, a detailed description of the company and parent company (if applicable), the products offered in South Carolina, market assessment, organizational structure, board summary, financial plan, and solvency summary, highlighting the company's vision, strategy, implementation timeline, and goals for Healthy Connections Medicaid. Applicants must disclose information related to ownership and control, significant business transactions, and persons convicted of crimes by completing SCDHHS Form 1514 and/or such other form as may be required by the Department or CMS.
4.57.	Applicants shall provide the Department with the following: • Financial statements as described in the Managed Care Process and Procedure Manual, including bank, account, line of credit, and loan information. • Recent audited financial statements for respondent and parent company as described in the Managed Care Process and Procedure Manual and Report Companion Guide	Applicants financial statements will be reviewed for completeness and to ensure the applicant maintains a sound financial condition.
4.58.	Provide all P&Ps and report examples of the process used for capitation reconciliation.	The MCO shall submit executed P&Ps, SOPs and internal reporting samples which show compliance to contract requirements in sections 7.3, 7.4, 7.10, 7.12, 11.6.4, and includes considerations from sections 15.6, 15.11, 17.11.3, 18.3-4.
4.59.	Provide all P&Ps and report examples of the process used for reconciling the claims system to the general ledger.	The MCO shall submit executed P&Ps, SOPs and internal reporting samples which show compliance to contract requirements in section D.1.5
4.60.	Provide all P&Ps and report examples of the process used for calculating and recording Incurred But Not Reported.	The MCO shall submit executed P&Ps, SOPs and internal reporting samples which show compliance to contract requirements in sections 3.10, 4.3.6, 4.8.7, 7.4, 14.1.7, 14.6.8

4.61.	Provide a description of how the Applicant will track and report on revenue and expenses for Medicaid — this may require specific identification of claims to enrollees and reporting at the population group level and how it will separately identify Medicaid revenue and expenses from other lines of business. The description shall include: • A description of the process utilized to monitor and reconcile encounters to financial reports. • Corporate cost allocation schedules and methodologies identified for Medicaid. • Allocation schedules and the methodology used to allocate administrative expenditures to general ledger accounts that are not directly chargeable to Medicaid. • Description of specific staff and administrative expenses directly charged to Medicaid. • A copy of any reinsurance agreements together with an overall description of the arrangements, including how they work to ensure the solvency of the MCO and that all incurred, unpaid claim liability will be covered in the event of the termination of the MCO due to insolvency or otherwise as required by 38-33-130(C). • A description of key performance indicators and the timing for reviewing these indicators. • A description of any parental guarantee that may be in place to ensure the solvency of the MCO, together with a copy of any such guarantee. • A copy of any parent company administrative service agreement or any other affiliated service agreements, together with evidence that the related Form D for any such agreement has been filed with and approved by the South Carolina Department of Insurance.	MCO shall submit coordination of benefits (COB) and subrogation claims processing P&Ps, SOPs, Organization Charts/structure, and internal reports/controls that ensure accurate payment oversight for members with secondary coverage. Analysis of the filings shall assess the methodology for monitoring and reconciling encounters to financial reports, checking for accuracy and reliability. Actuarial ledger oversight description, including org. chart, roles and responsibilities of team members, solvency attestation, and copy of any parent company administrative service agreement or any other affiliated service agreements, together with evidence that the related Form D. Description must include reinsurance agreements, cost allocation schedules and methodologies specific SC shall be reviewed to verify they align with industry standards and regulations.
4.62.	Provide all P&Ps for subcontractor and delegation oversight, as well as contingency plans and pre-delegation checklists. If the MCO has delegated claims processing and payment, or has a risk-bearing contract with a subcontractor(s), include the following: • A P&P and timeline for implementation of the quarterly and annual financial statements addition for subcontractors reporting to the plan. • The process for notifying the Department of insolvency concerns and how such concerns are determined and resolved.	P&Ps shall be reviewed to ensure full adherence of the requirements sets for in MCO Con Section 2.5, 2.6, 2.7 (if applicable), 11.1 including the oversight, contingency plans, onboarding plans, and delegation termination plans. Subcontractor timeline of financial reporting will be reviewed for completeness, controls, and industry standards. P&P and SOPs will be reviewed to ensure appropriate insolvency notifications for services from the MCO, or its subcontractors, to Department; and validation of Member billing considerations pursuant to MCO Con Sections 19.10 and D.1.2
4.63.	Provide all P&Ps describing the process for accepting, recording/ tracking, trending, and resolving enrollee filings of grievances, appeals, and State Fair Hearings. Include timelines for resolution and internal escalation. Include the communication protocols with subcontractors and Providers for research and resolution.	The Department will review P&Ps to ensure compliance with MCO Contract Section 9.1, ensuring appropriate notice to Members, accurate and timely processing and responses to members appeals and grievances, and procedures for handling of grievances and appeals.
4.64.	Submit for Department approval the Notice of Adverse Benefit Determination letter template.	The Department will review the letter to ensure readability, and compliance with all requirements in MCO Con Section 9.1.5.2 , including the determination, the reasons for the determinatino, and applicable appeal rights.

4.65.	Submit for Department approval the Notice of Plan Appeal Resolution letter template.	The Department will review the letter to ensure readability, and compliance with all requirements in MCO Con Section 9.1.6.2.3, including the results of the resolution process, the date it was completed, and the Member's rights.
4.66.	Submit for Department approval all other enrollee grievance and appeal templates including, but not limited to: • Grievance acknowledgement • Appeal acknowledgement • Extension request • Expedited appeal denial • Grievance resolution For all applicable grievance and appeal templates, provide a narrative summary explaining what scenario(s) each letter will be used for and the readability levels.	The Department will review the letter to ensure readability, and compliance with all requirements in MCO Con Section 9.1.
4.67.	Provide all relevant P&Ps, workflow, and organizational charts describing the process of managing an Adverse Benefit Determination. The documentation should include: • Processes outlining how Adverse Benefit Determinations are reviewed, • Staff used throughout the management of an Adverse Benefit Determinations, • Any systems where denial information is entered, stored, or made available for reporting, and • Processes for generating notice of adverse benefit determination letters, • Processes for ensuring consistency and accuracy of Adverse Benefit Determinations, and • Processes for responding to appeals, fair hearings or other levels of appeal resolution.	The Department will review P&Ps, workflows, and organizational charts to ensure compliance with MCO Cont Section 9.1. The review will include process assement to ensure appropriate, timely, and consistent reviews, as well as adherence to all established timeframes.
4.68.	Provide all P&Ps describing the Applicant's internal quality assurance and compliance process for responding to Member complaints, including those received from the Department. Include any associated processes for categorizing complaints, identifying trends, conducting root cause analyses when a patter of complaint is detected, and any escalation protocol for potential access to care issues.	The Department will review P&Ps to ensure compliance with MCO Contract Section 9, 15.4.3, and 18.1., including the presence of appropriate internal quality assurance and compliance processes.
4.69.	Provide all P&Ps for the continuation of Benefits, in some instances, during the Contractor-Level Appeal and the State Fair Hearing. The P&P should also describe how the Applicant will provide services promptly if an appeal is overturned by the MCO or when a Medicaid Fair Hearing Final Order is ruled in favor of the Member by the Department.	The Department will review P&Ps to ensure compliance with MCO Con Section 9.1, including all Continuation of Benefits and eeffectuation of erversed appeal resolutions
4.70.	Provide all P&P's describing the process of managing the Provider Dispute System.	The Department will review P&Ps to ensure compliance with MCO Contract Section 9.2 and will be reviewed to ensure provider disputes are processed in a consistent, timely, standardized, and complete method.

4.71.	Provide all P&Ps and a written Marketing Plan describing the ability to meet general marketing requirements. Provide all marketing materials the applicant anticipates using in the first six months of operation.	The Department will review P&Ps to ensure compliance with MCO Con Section 12 and applicable provisions of the CFR. A process shall be in place to ensure appropriate communication with Marketing Materials and Activities will be conducted in accordance with 42 CFR 438.104 and include consultation with the Medical Care Advisory Committee (MCAC) or an advisory committee with similar membership.
4.72.	Provide all P&Ps and SOPs for translation services, including how information regarding an enrollee's preferred language is obtained, the process to provide enrollees with information in their preferred language, how interpreter and translation services are made available (including the use of auxiliary aids), how the interpretor will interact with case management staff, and any bilingual/multilingual staff. If translation services are to be delegated to a subcontractor, provide the subcontract or, if not yet executed, provide a description of the timeline for acquiring translation services and the approach to contracting.	The Department will review P&Ps and SOPs to ensure compliance with MCO Con Section 2.5, including delegation agreement which demonstrates auditing completeness and comprehensive planning for translation interpreter services available any beneficiaries in need of such services. MCO narrative shall include org. chart and summary of team member roles and responsibilities that ensure oversight and maintenance of MCO's translation services.
4.73.	Provide links for enrollee materials (e.g., enrollee handbooks, provider directory, etc.). Include a site map for all SCDHHS-related information. If online information and links are not finalized, submit the timeline for completion. Include a description of website compliance with literacy levels, language and format. Include a description of all supplemental information available to enrollees (e.g., enrollee portals, newsletters, educational materials, links to external resources, etc.).	The Department will review all provided information to ensure compliance with MCO Con Section 3.12.
4.74.	Provide all P&Ps for the method(s) the MCO will use to distribute initial enrollment documents (e.g., enrollment notice and welcome notifications, enrollee handbooks, enrollee ID cards, provider directories), including ensuring timeliness.	The Department will review P&Ps to ensure full adherence of the requirements sets for in MCO Contract section 3.12 including the timeliness and necessary beneficiary provisions.
4.75.	Submit for SC DHHS approval the enrollee identification card template(s).	The Department will review the templateto ensure it contains all required elements set forth in MCO Contract section 3.12
4.76.	Submit for SC DHHS approval the layout of the hard copy provider directory.	The Department will review the provier directory layout to ensure it contains all required data elements set forth in MCO contract section 3.12
4.77.	Provide a narrative summary describing the accessibility of the online searchable directory, including searchable parameters and the accessibility from mobile devices. Provide screen shot examples showing click-by-click provider search results, and a project plan that includes deadlines and timeframes for implementation of the MCO’s online searchable provider directory and the link(s) to be utilized. Include all P&Ps for the online searchable provider directory and the timeliness of updates.	The Department will review the narrative summary to ensure it clearly describes the directory's accessibility, search parameters, and mobile compatibility. It is expected that the provided screenshots will demonstrate user-friendly search process with relevant results. The project plan will be reviewed for realistic deadlines, timeframes, and the directory link(s) to be used. P&Ps for directory management shall be reviewed for adherence to MCO Contract section 3, focusing on the frequency and timeliness of updates to ensure accurate and up-to-date provider information.

4.78.	Provide a narrative summary describing the Applicant's use of communication methods and technologically advanced resources, such as enrollee website portals, social networking, focus groups, and/or smartphone applications (apps) for engaging enrollees. Provide all P&Ps for the secure use of these communication methods.	The Department will review the narrative summary for comprehensivity and innovation. P&Ps will be reviewed to ensure compliance with MCO Con Section 3.
4.79.	Submit for SC DHHS approval all enrollee communication materials that will be utilized by the MCO or the MCO's subcontractors, for the SC Medicaid program that are not submitted as part of any other section. Provide the MCO's priority request for the SC DHHS's review of such documents by completing linked tool.	The Department will review materials for compliance with readability requirements and all applicable contract requirements.
4.80.	Provide all P&Ps for ensuring the confidentiality of Members' diagnosis of a specialty condition in distribution of all enrollee materials.	The Department will review P&Ps, SOPs and delegation agreements adequacy of ensuring HIPAA compliance with Sections 14.1, 14.3, 14.5, 14.6, 14.7, 14.11, 19.1 - 19.5, and Appendix C of the MCO Contract
4.81.	Submit for SC DHHS approval all telephonic scripts used by staff and hold line message information, including readability levels. Include subcontractor telephonic scripts used by their staff and hold line message information, including readability levels, if they will have an enrollee toll-free line.	The Departent will review Member communications for completeness, clarity, and readability levels.
4.82.	Provide copies of all system generated reports available from the Applicant's call management system that the plan will use to monitor, track and managing performance for all Call Center Performance Standards.	The Department will review reports to ensure that they are sufficient to ensure compliance with MCO Con Section 3.17, including the established Call Center Performance Standards and all data elements described in the Call Center Performance Report in the Managed Care Report Companion Guide.
4.83.	Provide documentation of functionality (including ability of phone system to track call management metrics) of toll-free provider and enrollee services line and provide the toll-free number(s) the Department should see across all materials. Provide a list of all contact numbers available for members and providers to engage with the health plan, including Interactive Voice Response (IVR) menus, IVR call flow diagram, and hours of operations for each contact channel. This includes email and chat functionality, if offered.	The Department will review the documentation and approach for completeness, clarity, and ease of use by users.
4.84.	Provide all P&Ps and SOPs demonstrating how the Applicant promotes the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, or sexual orientation. Provide the resume of the Member Service Manager Key Personnel position.	Resume of Member Service Manager Key Personnel position and P&Ps, SOPs will be reviewed for compliance with Section 3.14.4, 5.3.5.3, and 6.1.13, including the ability to promote delivery of services in a culturally competent manner.
4.85.	Provide all P&Ps and SOPs describing the process for Member enrollment/disenrollment, including receipt of and monitoring of 834 files, system load turnaround time (TAT), and vendor notification.	The Department will review P&P and SOPs to ensure compliance with Sections 3, 4.9.4, 5.1.1, 5.6, 10.6-7, 11.10.3, 14.2.1, 14.4, 14.7, 16.4.2, 17.6-7, 17.10 The Applicant must demonstrate completeness and accuracy of enrollment oversight reports detailing receipt of 834 files, system load TAT, and vendor notification

4.86.	Provide a draft Member handbook for review. Provide P&Ps describing how Applicant will ensure the Member handbook is updated, continuously meets contractual requirements, and is provided timely to the Member.	The Department will review P&P and SOPs to ensure compliance with Sections 3.12.2, 3.14.2.5, 4.2.22.5, 4.3, 9.1.2, and 16.8. Handbook should be bookmarked for compliance references to facilitate SC DHHS review for these MCO contract sections, as well as Section 12 of the Medicaid Managed Care Process and Procedure Manual.
4.87.	Provide all P&Ps for ensuring and monitoring timely appointment access requirements. Describe the methodology used to verify appointment access.	The Department will review P&Ps and appointment verification methodologies to ensure compliance with: 1. SCDHHS appointment access standards as outlined in Section 6.2 of the MCO Contract, and 2. Requirements under CMS-2439-F, including adherence to maximum appointment wait time standards.
4.88.	Provide an initial network development plan. Provide P&Ps regarding completion of the annual network development plan and associated components.	The initial network development plan and associated P&Ps must comply with and include all items listed in MCO Con Section 6.6.2. Documents will be reviewed to ensure the Contractor's ability to develop, maintain, and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this contract.
4.89.	Provide all P&Ps and SOPs regarding non-contracted providers, including how the applicant will coordinate with non-contracted providers to ensure Members will not be balance billed and that non-contracted providers will receive appropriate payment for services.	The Department will review P&Ps to ensure compliance with MCO Con Section 6.5. P&Ps will be reviewed to ensure that in situations in which the Contractor's network is unable to provide Medically Necessary Core Benefits the Contractor effectively covers these services and coordinates with non-contracted providers regarding not billing beneficiaries and payment.
4.90.	Provide all P&Ps and SOPs regarding required provider network submissions, changes to network participation, and associated notifications to the SC DHHS. Include the methodology used to ensure the adverse changes do not impact provider network adequacy requirements and the templates used to inform enrollees of changes to the provider network.	The Department will review P&Ps and SOPs for compliance with MCO Con **Section 6.3**. The Provider network submission must abide by requirements detailed in the Managed Care Process and Procedure Manual and follow the format outlined in the Managed Care Report Companion Guide. Contractors templates for member communication should abide by all requirements in MCO Contract **Section 3.14**.
4.91.	Provide a draft Provider handbook for review. Provide a P&P that describes how the provider handbook is kept up to date and distributed as needed.	The handbook must adequately describe provider responsibilities in compliance with the MCO contract. The Department will review P&Ps to ensure compliance with all requirements in MCO Con Section 6 and includes a process to update any changes set forth by the Department during the contract period.
4.92.	Provide all P&Ps for provider training. Include specific training for non-participating providers on prior authorization processes during the continuity of care period. Provide the Applicant's provider training plan, including a proposed calendar of provider training activities for the first Contract Year. Provide all subcontractor training plans.	The Department will review P&Ps to ensure compliance with all requirements in MCO Con Section 2.3, 5, 6, and 16.10 demonstrating oversight and reporting capabilities. The proposed calendar and training plans shall be reviewed to ensure adequate scope and continued training will be available during the MCO's first year.

4.93.	Provide a narrative summary describing the MCOs provider engagement model, including staffing approach, Provider onboarding and training, communication plan, utilization of performance feedback, and establishing and maintaining a local presence. The summary should include timeframes and milestones of pre- and post-Go Live activities.	The Department will review the narrative summary to ensure it is designed to foster strong relationships with providers, enhance communication, and promote high-quality care delivery.
4.94.	Provide all P&Ps for recognizing patient-centered medical home programs (PCMH) and providing increased compensation for those PCMHs.	The Department will review P&Ps to ensure compliance with all requirements in MCO Con Sections 6 and 15, demonstrating oversight and reporting capabilities
4.95.	Provide all P&Ps on pharmacy encounter data submissions, supplemental reporting, and methods the plan will use to ensure the amount paid to pharmacies (Providers) is captured in the encounter data submitted to the Department.	The Department will review P&Ps to ensure compliance with MCO Con Sections 7.2 and 14.6, including the maintenance of adequate systems, policies, and procedures to ensure that encounter submissions are complete and accurate.
4.96.	Provide all P&Ps detailing the ability to exercise sound fiscal management.	The Department will review P&Ps to ensure compliance with MCO Con Section 7 and must demonstrate appropriate oversight to monitor adherence to all payment requirements.
4.97.	Provide all P&Ps detailing the MCO's ability to meet Medical Loss Ratio (MLR) requirements, including compliance with federal and state-level MLR calculation methodologies, MLR Calculations and Formulas aligned with federal standards, and processes for return of funds.	The Department will review P&Ps to ensure compliance with all requirements in SCDHHS MCO Contract 7.2.
4.98.	Provide all P&Ps detailing the Applicant's ability to provide the necessary reports to the Department for Managed Care Capitation Payment certifications and meet other Capitation Payment requirements.	Department will review P&Ps, SOPs and internal report controls to ensure full compliance with Section 7.3
4.99.	Provide a narrative summary describing the projected volume of EDI transactions versus paper by claim type. Include a description of how paper claims are received, tracked and queued for adjudication. Include a P&P that contains the Applicant's oversight process for claims that require manual adjudication (i.e., how volume by provider type/ service is assessed and tracked and the timeframes for resolving any issues with auto-adjudication so that manual processing is no longer necessary).	The narrative summary shall be reviewed to ensure the process encompasses complete, timely end to end process. MCO must submit P&Ps, SOPs and internal control reporting demonstrating compliance to MCO Contract requirements in Sections 7.2.1.9, 10.3.4, 11.4, 14.3, 14.4, 14.6.14-16, 14.9.5, 17.10
4.100.	Provide all policies, procedures, methodologies, timelines and monitoring plans regarding payments to in network providers to include hospitals, rural health clinics, federally qualified health clinics, and Indian Health Care Providers (IHCP)	The Department will reveiw P&Ps, SOPs and internal control reporting to ensure compliance with MCO Con requirements in Sections 7.4.1-4, 7.7.5, 9.2.3, 14.6.14, and Appendix D.2.2 (including P&Ps, SOPs and oversight reporting for subcontractors managing delegated claims processing and/or encounters)
4.101.	Provide all P&Ps and SOPs for claims and quality audit trainings. Include the training curricula, how the trainings are performed, frequency, length of trainings, subjects that are covered, and re-training requirements. Include how accuracy is ensured for the claims processing units.	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with MCO Contract requirements in Sections 2.1.5, 2.1.6, 2.3, 8.2.1.10, 11.2.1.4, 11.2.4, 11.2.7 and Appendix E.

4.102.	Provide all P&Ps, methodologies, and monitoring plans to ensure there is no Cost Sharing / Copayments on Medicaid Managed Care members, regardless of service type or setting, including how this is communicated to the Member. P&Ps should describe how the Applicant will exempt from premiums any Indian who is eligible or has received an item or service furnished by an IHCP or through referral under contract health services.	The Department will review P&Ps, SOPs, and internal control reporting demonstrating compliance to MCO Con requirements in Sections 3.12.2.5, 7.5, 7.6, and 9.1.
4.103.	Provide all P&Ps regarding payment of emergency services rendered by non-contracted providers.	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with MCO Con requirements in Sections 7.7
4.104.	Provide all P&Ps regarding payment standards. P&Ps should include monitoring plans to ensure that all provided services are medically necessary, that Providers Health Records or other documentation substantiates the need for services, and that the Applicant is fulfilling timely claims payment requirements.	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with MCO Con requirements in Sections 7.8 and 14.10.2
4.105.	Provide all P&Ps to ensure that the Applicant will not make payment for the following, as described and defined in the MCO Contract: • Non-Emergency Items or Services • Assisted Suicide • Home Health • Hospital-Acquired Condition (HAC) or Provider-Preventable Condition (PPC) • Individuals or Entities Pending Fraud Investigation • Other Non-State Plan Covered Services	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with MCO Con requirements in Sections 7.9
4.106.	Provide all P&Ps, SOPs, and methodologies for conducting periodic and annual financial audits, including an annual audited financial report; an independent audit of the accuracy, truthfulness, and completeness of Encounter data and financial data; and a Medicaid-specific annual independent audit report.	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with MCO Con requirements in Sections 7.10 and 16.4.2, and conform to requirements for submission in the Managed Care Process and Procedure Manual.
4.107.	Provide all P&Ps and SOPs related to the return of funds to the Department.	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with MCO Con requirements in Sections 7.2.4, 7.3, and 7.10.
4.108.	Provide all P&Ps, SOPs, and internal control reporting demonstrating the Applicant's ability to adhere to contract requirements regarding Medicaid provider tax returns.	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with MCO Con requirements in Section 7.12

4.109.	Provide all P&Ps, SOPs, and timelines regarding SCDHHS State Directed Payment Programs, including: • Supplemental Teaching Physician Program • Rural Hospital Minimum Fee Schedule • Health Access, Workforce, and Quality • Independent Community Pharmacy Directed Payment Program • Ambulance Supplemental Payment Program	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with MCO Con requirements in Section 7.4.
4.110.	Provide the P&Ps for the Statewide Pharmacy Lock-in Program (SPLIP), including how the Applicant will conduct secondary reviews to identify Members that would not benefit from the SPLIP, methods for notification Members of lock in status and their designated pharmacy, point-of-sale processes to restrict members to a designated pharmacy, and how the Applicant will meet established lock-in timelines. The Applicant should provide its SPLIP template letter and instructions, if the Applicant chooses to modify the Department's existing templates. If the Applicant proposes to have a pharmacy lock-in program that utilizes more stringent criteria than the Department's Pharmacy Lock-in Policy and Guidelines please use the companion tool to define the more stringent criteria.	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with MCO Con requirements in MCO Con Section 11.10.
4.111.	Provide all P&Ps, methodologies, monitoring plans, and timelines regarding program integrity, the mitigation of fraud, waste or abuse (FWA), and ensuring services were delivered as required and billed.	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with MCO Con requirements MCO Contract Section 11.1.
4.112.	Provide a draft Compliance Plan that demonstrates the Applicants commitment to complying with all applicable requirements and standards under the contract and meets requirements established in the Managed Care Report Companion Guide. Provide all associated P&Ps, SOPs, staffing plans, organizational charts, training and education plans, and standards of conduct demonstrating ability to meet Compliance Plan requirements.	The Department will review P&Ps, SOPs and internal control reporting to ensure compliance with all requirements in SCDHHS MCO Contract section 11.2. The staffing plan will be reviewed to ensure compliance with MCO Con 11.2.2. The Department will review the Compliance Plan to ensure it contains all elements required by the Managed Care Report Companion Guide.
4.113.	Provide all P&Ps, methodologies, and specific controls in place for prevention and detection of potential or suspected FWA. The P&P should include a narrative description of the controls, the system that performs them, their function, and any procedures or processes that may result from the controls.	The Department will review P&Ps to ensure compliance with MCO Con Section 11.3.
4.114.	Provide all P&Ps, methodologies, and specific activities related to reviews, investigations, and audits	The Department will review P&Ps to ensure compliance with MCO Con Section 11.4.
4.115.	Provide all P&Ps, methodologies, algorithms, and monitoring plans regarding program integrity referral coordination and cooperation.	The Department will review P&Ps to ensure compliance with MCO Con Section 11.5.
4.116.	Provide all P&Ps, monitoring plans, and timelines related to overpayments, recoveries, or refunds.	The Department will review P&Ps to ensure compliance with MCO Con Section 11.6.

4.117.	Provide narrative describing the Applicant's ability to provide cooperation and support in program integrity investigations, hearings, and disputes.	The Department will review the narrative to ensure compliance with MCO Con section 11.7.
4.118.	Provide all P&Ps regarding the suspension of payment to a Provider for which the Department determines there is a Credible Allegation of Fraud.	The Department will review P&Ps to ensure compliance with MCO Con Section 11.8.
4.119.	Provide all P&Ps regarding prepayment review, to include any information systems leveraged, criteria or standards used to ensure claims meet the requirements of federa and state laws and regulations, and a monitoring plan for any results.	The Department will review P&Ps to ensure compliance with MCO Con Section 11.9.
4.120.	Provide full and complete information on the identity and address of each person or corporation with an ownership or control interest in the Applicant as defined in the MCO Contract. Information should be provided to the Department on the approved Disclosure of Ownership and Control Interest Statement.	Documentation must address at a minimum, all requirements in MCO Con section 11.11, including adherence to established due dates and minimum information.
4.121.	Provide all policies and procedures related to addressing provider and employee exclusions, debarment, and terminations	P&Ps must address at a minimum, all requirements in SCDHHS MCO Contract section 11.12.
4.122.	Provide attestation affirming the Applicant does not knowingly have a prohibited affiliation or relationship with individuals debarred by Federal Agencies.	The Department will review the attestation to ensure conformity with MCO Con 11.13.
4.123.	Applicants (including the applicant's parent, affiliate(s), or subsidiary(ies) must provide detail regarding their experience in achieving quality standards with populations similar to those that will be covered by the MCO, including any special population groups and members with Special Health Care Needs described in Section 4 of the MCO Contract. MCO must submit a health risk assessment tool to identify members with Special Health Care Needs.	SCDHHS will review applicant submissions to ensure the requisite experience and achievement of quality standards. SCDHHS will review the health risk assessment tool to ensure alignment with best practice and/or established methodologies to identify members with Special Health Care Needs.
4.124.	The applicant shall submit to the Department policies and procedures related to the collection, reporting, and submission of all measures specified in the MCO P&P Manual, including HEDIS measures and other measures that are not part of HEDIS, such as, the CMS Adult and Child Core Quality Measures. Applicants must demonstrate their ability to: • Measure and report standard measures as required by the Department. • Provide the Department with the data necessary to measure and analyze performance for quality metrics.	Deemed partially completed with successful achievement of NCQA Health Plan accreditation (Gate 2) and EQR results (Gate 3). Additionally, MCO must: • Present evidence of its contract with a NCQA-licensed audit organization • Demonstrate their ability to stratify data and submit all HEDIS and CMS core set measures.
4.125.	The applicant shall submit to the Department policies and procedures related to the collection, reporting, and submission of all CAHPS surveys - and other methods of collecting Member-related information (e.g., additional Member surveys) - outlined in the MCO P&P Manual. The MCO must also demonstrate its ability to provide data in an editable format that allows for aggregation and analysis of the raw data.	Deemed partially completed with successful achievement of NCQA Health Plan accreditation (Gate 2) and EQR results (Gate 3). Additionally, MCO must: • Present evidence of its contract with an NCQA certfied CAHPS survey vendor. • Demonstrate its ability to provide data to the Department as outlined in MCO Contract 15.4.2.2.

4.126.	Provide narrative description of three completed quality improvement (QI) projects in comparison states, through which the applicant achieved improved health outcomes. The applicant shall state the key metric for the project, the baseline measure of the key metric before QI project implementation, the reassessment of the key metric after QI project implementation, the absolute value of relative percentage improvement in the key metric between baseline and reassessment, and the percent of enrollees in the contract that were targeted by the QI project. Applicant's should include projects that address childhood health, behavioral health, or maternal and infant health outcomes.	The Department will review QI projects performance to identify how the applicant's efforts improved outcomes across time.
4.127.	Provide prospective performance improvement projects (PIP)s in accordance with contract requirements. PIPs must identify alignment with agency strategic goals and include a monitoring plan.	The Department will review PIPs to ensure alignment with MCO Con 15.2, including: • Measurement of performance using objective Quality measures and indicators. • Implementation of system interventions to achieve improvement in the access to and quality of care. • Evaluation of the effectiveness of the intervention(s). • Planning and initiation of activities for increasing or sustaining improvements realized through the PIP. Additonally, the Department will review the applicant's PIP monitoring plan to track and evaluate changes in outcomes, care delivery, etc.
4.128.	Provide a narrative describing the role, membership, and meeting frequency of the Quality Assurance Committee. Provide all P&Ps relating to the Quality Assurance Committee, including how meetings and activities are documented; how the Committee is responsible for all aspects fo the QAPI program; and the Applicants approach to measurement, analysis and interventions for QAPI activity findings.	For initial see Gate 2 outlines the evaluation criteria. Ensure quality standard that includes quality committee P&P and report requirements under Gate 2 inclusive of SCDHHS requirements align with NCQA.
4.129.	Provide a list of the accreditations and certifications/recognitions that the Applicant currently has and intends to pursue for the Medicaid line of business. For each accreditation or certification, provide the level (if applicable) and expiration date. Additionally, provide documentation of the most recent accreditation site visit, including documentation of all follow-up required by the accrediting organization.	Deemed partially completed with successful achievement of NCQA Health Plan accreditation (Gate 2). Additionally, MCO must present evidence of its contract with a NCQA-licensed audit organization
4.130.	Submit an analysis of the Applicant's compliance with the Mental Health Parity and Addiction Equity Act of 2008 as it applies to this Contract. The Applicant further affirms that it shall provide to the Department upon request, evidence of such compliance with the requirements of 42 CFR 438.3(n)(2), 42 CFR 438.3(e)(1)(ii), and 42 CFR 438 Subpart K, and any steps taken to comply with the Mental Health Parity and Addictions Equity Act including EQRO evaluation.	Department will review P&P and protocols to ensure compliance with MCO Con Section 15.

4.131.	Provide all P&Ps, materials and reports regarding the execution of all quality incentive program, including: Hospital Quality Achievement Program, Quality Withhold Program, and Bonus Program. The P&Ps should include a description of the program; any associated activities, targets, performance measures, or quality-based outcomes that are part of the program; how the program is linked to the Department's Strategic Plan; and how providers will be educated about and enrolled into the program.	Department will review P&P and associated program descriptions to ensure compliance with MCO Con Section 15.6
4.132.	Provide all P&Ps regarding the MCO's ability to comply with External Quality Review requirements. Please include description and reports of secret shopper program to ensure adherence to appointment wait time standards.	The Department will review P&Ps to ensure compliance with MCO Con 15.12, including participation and cooperation in an annual External Quality Review.
4.133.	Provide a narrative QAPI plan ensuring all quality management and performance activities are compliant with federal and state rules and regulations Plan must include, but is not limited to: • Program description, • Organizational structure and governance, • Work plan and evaluation to ensure assessment protocol, • Mechanisms to detect under/over utilization, • Quality assessment/appropriateness of care, • Measurement and reporting standards, • Accreditation timelines, • Network access and availability via adequacy standards, • Activities to identify and address health disparities, inclduing data collection, • Physical and behavioral health practice guidelines that includes monitoring plans regarding the dissemination of the practice guidelines, • Adult and Child Core Set reporting via HEDIS and non-HEDIS measurements, • CAHPS vendor arrangements, and • Marketing materials via member and provider communications.	The Department will review the QAPI plan to ensure compliance with MCO Con Section 15.1, other applicable section of the MCO Con, and Section 1932(c)(1) of the Social Security Act (SSA).

4.134.	Provide a detailed narrative description outlining how the Applicant intends to leverage alternative payment models (APMs) to improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes. The narrative should contain: • An overall description of the APM, including its goals • The type of payment methodology it will leverage • The geographic reach of the model • The types of providers that will be included, or are already contracted • The approach to onboarding and training providers to participate in the APM Provide all P&Ps describing the MCO's APM arrangements, including how the Applicant will meet the targets for each measurement year in accordance with the Contract and methodologies to support required reporting detailed in the MCO Process and Procedure Manual. Include a project plan with associated timeframes and milestones for APM implementation. Include subcontractors, as appropriate, throughout the strategy.	The Department will review the narrative for completeness and alignment with the Department's Strategic Plan. Additionally, SCDHHS will review P&Ps to ensure compliance with MCO Con Section 15.9.
4.135.	Provide a narrative description of the Applicant's management information systems' ability to collect, analyze, integrate, and report data on areas including, but not limited to: utilization, Claims, Grievances, Appeals, and Disenrollments. The narrative should include a list of all reports generated by the system. Provide all associated P&Ps, methodologies, protocols, and implementation timelines to meet reporting requirements.	The Department will review the narrative description and report list to ensure sufficiency of reporting capabilities and alignment with best practices. P&Ps to ensure compliance with MCO Con Section 13. Reporting methodologies, timelines, and protocols should be included to detail completeness and validity of formats, systems, and ensure all required data elements are included and available for reporting prior to start date.
4.136.	Certify that it has no Conflicts of Interest (COI).	Succesful submission of COI Certification and compliance with MCO Con 19.26.
4.137.	Provide attestation regarding understanding of Department responsibilities related to third party liability (TPL).	Filing only.
4.138.	Provide all P&Ps, protocols, and monitoring plans demonstrating the Applicant's ability to comply with TPL program requirements regarding: • Cost avoidance • Post-payment recovery • Retroactive eligibility for Medicare • Reporting disenrollment requests • TPL recoveries by the Department • Additional reporting requirements	The Department will review P&Ps, protocols and monitoring plans to ensure compliance with MCO Con Section 10.

4.139.	Provide a Utilization Management (UM) program description, including the processes and criteria used to evaluate medical necessity, appropriateness, and efficiency of services. The description should detail prior authorization procedures, concurrent and retrospective reviews, the use of evidence-based guidelines, and strategies to ensure timely and equitable access to care while minimizing unnecessary service utilization. Provide all P&Ps related to the following: • Utilization management program, including monitoring plans and medical necessity defintitions • Reporting requirements; including fraud, waste, and abuse, and the drug utilization review program • Dissemination of practice guidelines • Service authorizations, • Exceptions to service authorization requirements, including emergency services, post stabilization services, member transitions, women's healthcare services, and opioid treatment program clinic services • Emergency service utilization • Out-of-network use of non-emergency services	The Department will review P&Ps, protocols and monitoring plans to ensure compliance with MCO Con Section 8.2.
4.140.	Provide a narrative, including a workflow and associated timeframes for service authorization decisions and expedited service authorizations. Within the narrative, include timeframes that reflect the recent Final Rule that will require standard (non-urgent) requests to be decided within seven (7) calendar days and Urgent requests that must be completed within 72 hours as demonstrated via reports. (CMS-0057-F). Provide all relevant P&Ps, SOPs, and organizational charts related to the service authorization process, including, but not limited to Prior Authorization and concurrent authorization.	The Department will review the narrative and associated P&Ps, SOPs, and organizational charts to ensure alignment with MCO Con Sections 8.5 and 8.6, including all established timeframes.