REPORT COMPANION GUIDE

South Carolina Department of Health and Human Services

Healthy Connections Medicaid

July 1, 2024

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INTRODUCTION

MCO REPORTS TO SCDHHS

This Reports Companion Guide is specifically designated for reporting formats that are either required by the Division of Managed Care or are sent to the MCO's in relation to a department initiative. Details regarding the reports can be found in both the contract and the Managed Care Policy and Procedure Guide. All reports received by SCDHHS must be dated for the reporting month, quarter or year being detailed in the report (see below for specific examples and exceptions).

Monthly-- **Example**: *"Call Center Performance_201602"*

Explanation: Report Name then Calendar Year and Reporting Month (ex. February 2016 data submitted by March 15, 2016)

Quarterly-- **Example**: *"Provider Dispute Log_2016FQ1"*

Explanation: Report Name then State Fiscal Year and Fiscal Quarter (ex. July – September 2015 data submitted by October 31, 2016)

***** The Report Name should match the Report Requirements Full List below.**

If you have no data to report (ex: Manual Maternity Kicker or TPL COB Savings for pharmacy), still submit the appropriate template and designate that you have 'nothing to report'.

Exceptions: The standard file naming convention does not affect the Encounter Submission Summary, Provider Network file, nor PCMH files. See appropriate sections of this document or the report template for specific naming convention.

Specific Program Integrity (PI) or Third Party Liability (TPL) reports that are submitted directly to the PI SharePoint site or to an FTP site, do not need to be submitted to the Division of Managed Care/MCO SharePoint site.

If you have questions or issues regarding the reports you receive at your FTP site with the department, please contact the department's Information Technology helpdesk:

Contact:
EDI Support
Hours: 7:00 am to 5:00 pm Monday through Friday
Phone: 1-888-289-0709, Option 1 and then Option 2
https://www.scdhhs.gov/resource/electronic-data-interchange-edi

If you have questions about required report submissions or timelines for submission, please contact your account manager and they will assist you with your questions.

MANAGED CARE REPORTS LIST

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
SECTION 2- CONTRACTOR Administrative Requirements						
2.1	Organizational Chart	Specific Format not defined. MCO can utilize any format it chooses to present the data. Must be submitted within 10 business days of change in personnel.	Annually and Upon Change in Personnel	Ninety (90) Days after the end of a fiscal year. Within ten (10) Business Days of any change	CONTRACTOR	DEPARTMENT
2.2	Personnel Resumes	Specific Format not defined. MCO can utilize any format it chooses to present the data. Must be submitted for Key personnel within 10 business days of a change.	Upon Change in Key Personnel	Notification within ten (10) Business Days of any change with CV/resume submission. Monthly summary report using Key Personnel Changes report is due the fifteenth (15) Day following the end of the month.	CONTRACTOR	DEPARTMENT
2.2	Key Personnel Changes	Provides a list of key personnel changes including	Monthly	Fifteenth (15th) of every month	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
SECTION 3- Member Eligibility and Enrollment						
3.2	Eligibility Redetermination	Report produced for MCO's when someone is getting Medicaid eligibility redeterminations completed by SCDHHS.	Monthly	Fifteen (15) Calendar Days after the end of a period	DEPARTMENT	CONTRACTOR
3.2	834 Report Layout	MCO receives these reports on a daily basis providing information on membership enrollment.	Daily	Daily	DEPARTMENT	CONTRACTOR
3.11	Health Plan Initiated Disenrollment Form	Required for requesting member disenrollment. Document can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary	Ad Hoc, As Necessary	DEPARTMENT	CONTRACTOR
3.17	Call Center Performance	Call center performance metrics for Member English language line, Member Spanish language line, and Provider call center.	Monthly	Fifteen (15) Calendar Days from the end of the month	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
SECTION 4- Core Benefits and Services						
4.1	All CONTRACTOR Policies and Procedures	A full list of the CONTRACTOR's policies and procedures, including any policy and procedure updates.	As Necessary; Annually	Within ten (10) business days of a change and within ninety (90) Days of the end of the state fiscal year	CONTRACTOR	DEPARTMENT
4.2	Universal PA	Required of providers requesting prior authorization (most) pharmaceuticals. Document can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
4.2	Universal Synagis PA	Required of providers requesting Synagis. Document can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
4.2	Institution for Mental Disease (IMD)	Report provided to MCOs for members age 21-64 with an IMD stay exceeding 15 days.	Annually	180 Days following the end of the fiscal year	DEPARTMENT	CONTRACTOR

4.2	High Cost No Experience (HCNE) Drug	Reimbursement for high cost no experience pharmaceuticals.	Monthly	Fifteen (15) Calendar Days from the end of the month	CONTRACTOR	DEPARTMENT
4.2	Drug Utilization Review (DUR)	Annual drug utilization review for all pharmacy claims.	Annually	Due May 31st of each year	CONTRACTOR	SCDHHS PHARMACY
4.3	Additional Services Request Form	Required for requesting additional member services that an MCO would like to provide to encourage desired member outcomes.	Ad Hoc, As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
4.3	Additional Services Template	A comprehensive list of all Additional Services the plans offer along with descriptive information about each service.	Annually	September 15th of each year	CONTRACTOR	DEPARTMENT
4.3	Expanded Benefits Chart	A list of the expanded benefits that different health plans offer beyond state covered services.	Annually	September 15th of each year	CONTRACTOR	DEPARTMENT
4.3	Additional Services Evaluation Report	This report shall act as a review of all the new Additional Services the MCO offers to its Members and the effectiveness of those services.	Quarterly	Thirty (30) Calendar Days after the end of a quarter	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
4.8	Member Incentives	Required for requesting additional member health incentives that an MCO would like to provide to encourage desired member outcomes.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
SECTION 5- Care Coordination and Case Management						
5.4	Case Management Program Description	Description of CONTRACTOR's Case Management Program, including levels of case management description and determination.	Annually	June 1st of each year	CONTRACTOR	DEPARTMENT
5.4	Care Management Report	Report of members receiving care management services on an ongoing basis with the MCO.	Monthly	Fifteen (15) calendar Days from the end of the month	CONTRACTOR	DEPARTMENT
5.5	Universal Newborn PA	Required for out-of-network pediatric providers to obtain an authorization for services rendered in the office during the first 60 days after discharge.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
SECTION 6- Networks						
6.2	Network Adequacy	Adequacy report sent to the MCOs within ten (10) business day of receipt from 3rd party vendor	Bi-Annually	Sept 15th and April 15th of each year	DEPARTMENT	CONTRACTOR
6.3	Provider Network Report	MCO report sent to SCDHHS reflecting MCOs entire provider network.	Quarterly	July 15th & January 15th; As Necessary	CONTRACTOR	DEPARTMENT
6.6	Annual Network Development Plan	A detailed description of the MCO's provider network development plan to ensure provider network adequacy.	Annual	Sept 1st of each year	CONTRACTOR	DEPARTMENT
SECTION 7- Payments						
7.2	Medical Loss Ratio (MLR)	Medical Loss Ratio Calculation report indicating the proportion of premium revenues spent on clinical services and quality improvement.	Annual	Report Due ten (10) months after the end of a fiscal year	CONTRACTOR	DEPARTMENT
7.3	Annual Rate Survey	DHHS sends out the Annual Rate Survey to the MCOs. The MCOs complete the survey and return to DHHS. Milliman uses this information to develop capitation rates for the coming state fiscal year.	Annually	Due date established by the Department when request sent to MCOs annually.	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
7.3	Dual Medicare Medicaid	Report produced for the MCOs to account for retro-active dual eligible Medicare recoupments for up to a year in arrears.	Monthly	The fifteenth (15th) Day of the following month	DEPARTMENT	CONTRACTOR
7.3	Monthly Premium Recoupment	Report produced for the MCOs for all members that received a premium payment in error; includes deceased members and duplicate member IDs	Monthly	The fifteenth (15th) Day of the following month	DEPARTMENT	CONTRACTOR
7.3	Patient Centered Medical Homes (PCMH) Assignments	MCO's submission is monthly, SCDHHS pays the MCO's on a quarterly basis. Utilized to reimburse those primary care practices that qualify for this incentive payment.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	DEPARTMENT
7.3	Patient Centered Medical Homes (PCMH) Payment Summary	MCO's submission is monthly, SCDHHS pays the MCO's on a quarterly basis. Utilized to reimburse those primary care practices that qualify for this incentive payment.	Quarterly	No later than sixty (60) Days from the end of the quarter	DEPARTMENT	CONTRACTOR

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
7.3	Manual Maternity Kicker	Maternity Kicker Report to be utilized when automated process does not function correctly.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	DEPARTMENT
7.3	MCO Withhold	Report template shared with the MCO to indicate quarterly withholding done to MCO's.	Quarterly	Thirty (30) Calendar Days after the end of a quarter	DEPARTMENT	CONTRACTOR
7.3	Premium Payment Adjustments	DHHS retroactive rate adjustment format to MCO PMPMs.	As Necessary	Ad Hoc, As Necessary	DEPARTMENT	CONTRACTOR
7.4	FQHC Wrap Payments	Current FQHC reports required for wrap payment process.	Quarterly and Annually	No later than sixty (60) Days from the end of the quarter; 60 days after the end of a fiscal year.	CONTRACTOR	DEPARTMENT
7.4	RHC Wrap Payments	Current RHC reports required for wrap payment process.	Quarterly and Annually	No later than sixty (60) Days from the end of the quarter; 60 days after the end of a fiscal year.	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
7.4	FQHC Prospective Payment System (PPS)	Reconciliation report for all FQHC payments with PPS amount.	Quarterly and Annually	No later than sixty (60) Days from the end of the quarter; Sixty (60) Days after the end of a fiscal year	CONTRACTOR	DEPARTMENT
7.9	Annual Audited Financial Statement	Should be the same report produced for the SC Department of Insurance.	Annually	By July 1st of each year	CONTRACTOR	DEPARTMENT
SECTION 8- Utilization Management						
8.3	Drug Utilization Review (DUR) Program Activities	Description of DUR program activities required annually.	Annually		CONTRACTOR	
8.3	Service Authorization Report	List of all service authorization requests including approval and denial reasons.	Quarterly and Annually	Thirty (30) Calendar Days after the end of the quarter; Ninety (90) Calendar Days after the end of a fiscal year	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
SECTION 9- Grievance and Appeal Procedures & Provider Disputes						
9.1	Member Grievance and Appeal Log	Grievance and Appeal reporting required of the MCO.	Quarterly and Annually	Thirty (30) Calendar Days after the end of a quarter; Ninety (90) Calendar Days after the end of a fiscal year	CONTRACTOR	DEPARTMENT
9.2	Provider Dispute Log	Provider dispute reporting required of the MCO.	Quarterly	Thirty (30) Calendar Days after the end of a quarter	CONTRACTOR	DEPARTMENT
SECTION 10- Third Party Liability						
10.9	TPL Casualty Cases	Any casualty cases that the MCO is aware are ongoing.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	DEPARTMENT
10.9	TPL COB Savings	T PL Coordination of Benefits (COB) report indicates those claims leading to coordination of benefits savings for the MCO.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	DEPARTMENT
10.9	TPL Cost Avoidance	T PL cost avoidance report indicates those claims that the MCO has cost avoided during the month.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
10.9	TPL Recoveries	Recoveries that the MCO have made as a result of research for members with potential or known third party coverage.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	DEPARTMENT
10.9	TPL Verification	T PL Verification Report indicates those members the MCO indicates have third party insurance coverage. This report is submitted via the departments FT P site.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	DEPARTMENT
SECTION 11- Program Integrity						
11.1	Provider Fraud Referral Form & Provider Waste and Abuse Referral Form	Forms for reporting potential provider fraud and potential waste and abuse. Both forms are located on the Program Integrity SharePoint site.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
11.1	Member Referral Form	Form for reporting potential member abuse and fraud issues that can be found on the Program Integrity SharePoint site.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Vetting Form	Report is Department-issued to Managed Care Organizations (MCOs) for action by MCO to validate the findings of the PI investigation.	As Necessary	Ad Hoc, As Necessary	DEPARTMENT	CONTRACTOR

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
11.1	Beneficiary Explanation of Medicaid Benefits (BEOMB)	BEOMB form for reporting instances where a member indicates that they did not receive a service from a provider.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
11.1	Provider Exclusions	SharePoint templates for reporting provider exclusions.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
11.1	Provider Suspensions	SharePoint templates for reporting provider suspensions.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
11.1	Provider Terminations	SharePoint templates for reporting provider terminations.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
11.1	Good Cause Exception (GCE) Form	Notifies the MCOs of a potential fraud referral for a provider of which they may request a payment suspension exception.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
11.1	Permissions Form	To request permission to conduct a targeted BEOMB run.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
11.1	Termination Denial for Cause Report	MCO Monthly reporting of terminated providers that should be submitted directly to PI's SharePoint site.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	SCDHHS PROGRAM INTEGRITY

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
11.1	MCO Quarterly Report	Quarterly reporting of fraud and abuse. This report should be submitted directly to Program Integrity's SharePoint site.	Quarterly	No later than thirty (30) calendar days after the end of each quarter	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Annual Strategic Plan	Strategic Plan Matrix can be found at PI SharePoint site.	Annually	At a date as determined by the Department	CONTRACTOR	DEPARTMENT
11.2	Written Compliance Plan	Annual Compliance Plan Matrix can be found at PI SharePoint site.	Annually	Within a ninety (90) calendar day period after the full execution of this contract, and annually thereafter	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
SECTION 12- Marketing Requirements						
12.3	Marketing Materials	Copies of any marketing materials the MCO will be using related to Medicaid services.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
12.3	Marketing Activities Submission Log	Log MCOs use to notify DHHS of upcoming marketing activities.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
SECTION 13- Reporting Requirements						
13.1	Claims Payment Accuracy	Report detailing monthly claim payment by the MCO.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	DEPARTMENT
13.1	Graduate Medical Education (GME)	Report detailing payment for Graduate Medical Education Providers and Institutions.	Quarterly	The thirtieth (30th) following the close of each quarter	CONTRACTOR	DEPARTMENT
13.1	Psychiatric Residential Treatment Facility (PRTF)	Report detailing MCO members in or recently discharged from a PRTF.	Monthly	Fifteen (15) Calendar Days from the end of the month	CONTRACTOR	DEPARTMENT
13.1	South Carolina Department of Insurance or National Association of Insurance Commissioner (SCDOI/ NAIC)	Reports on financials that must be provided within five (5) working days after the SCDOI/NAIC due date plus any extensions.	Quarterly and Annually	Within five (5) working days after the SCDOI/NAIC due date plus any extensions	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
SECTION 14- Encounter Data, Reporting, and Submission Requirements						
14.5	Encounter Submission Summary	Report detailing totals for monthly claims paid, accepted encounters, rejected encounters, and completeness percentage.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	DEPARTMENT
14.6	Encounter Data	All member encounter data.	Daily, Weekly, Monthly	By the end of the month for the previous month's Encounters	CONTRACTOR	DEPARTMENT
14.8	FQHC/RHC Encounter Reporting	Quarterly report of encounter claims data organized by date of service for all contracting FQHC & RHCs for the State Plan required for reconciliation purposes.	Quarterly	Within sixty (60) days of the end of each quarter	CONTRACTOR	DEPARTMENT
14.10	Encounter Quality Initiative (EQI)	Encounter Quality Initiative (EQI) Report	Quarterly and Annually	Within one hundred and twenty-one (121) Days of the end of each calendar quarter	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
SECTION 15- Quality Management and Performance						
15.1	Population Assessment Report	Copies of NCQA reports that are reviewed by the DEPARTMENT.	Annually	Date Set by MCO Quality Committee	CONTRACTOR	NCQA & DEPARTMENT
15.2	Quality Assessment & Performance Improvement Projects	Submitted quarterly to DEPARMENT and annually to Constellation.	Quarterly and Annually	Thirty (30) Calendar Days after the end of the quarter	CONTRACTOR	DEPARTMENT & CONSTELLATION HEALTH
15.4	Healthcare Effectiveness Data and Information Set (HEDIS) Reporting	Member satisfaction information. NCQA defined.	Annually	By July first (1st) for previous calendar year	CONTRACTOR	DEPARTMENT
15.4	Consumer Assessment of Healthcare Providers and Systems (CAHPS) Reporting	Member satisfaction information. NCQA defined. Submitted to both NCQA and SCDHHS.	Annually	By July 1st for previous calendar year	CONTRACTOR	DEPARTMENT
15.7	Alternative Payment Model (APM) Contracting	Annual Alternative Payment Models. May be requested Ad Hoc, to be provided within three (3) business days of the Date of Request, unless otherwise specified by the Department.	Annually or Ad Hoc	By April thirtieth (30th) of each year or within three (3) Business Days of the date of request	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
SECTION 16- Department Responsibilities						
16.3	Q&A GRID	As necessary for the MCO to ask questions of their account manager. Q&A document is updated regularly on the SharePoint site.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
APPENDIX E- BabyNet						
Appendix E	BabyNet Members	Report of members receiving BabyNet Services.	Monthly	By the 1st Monday of every month	DEPARTMENT	CONTRACTOR
Appendix E	BabyNet Providers	Report of BabyNet Providers.	Monthly	By the 1st Monday of every month	DEPARTMENT	CONTRACTOR

SECTION 2- CONTRACTOR ADMINISTRATIVE REQUIREMENTS

Section 2.1: Organizational Charts: There is no specific required format for this annual report. See contract and P&P for details. Please upload the annual report to the MCO's Annual Library under Required Submissions in SharePoint.

Section 2.2: Personnel Resumes: There is no specific required format for this report. See Contract and P&P for details. Whenever changes are required, upload to the Required Submissions library in SharePoint.

SECTION 3- MEMBER ELIGIBILITY AND ENROLLMENT

Section 3.2: 834 Report Layout

The 834 transaction file layout can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates. Additional information regarding the 834 transaction file may also be found in Appendix D in the *Maximus Reports* chart.

Section 3.2: Redetermination Report

There are two redetermination reports. These reports are produced for the MCO's to indicate whom is getting Medicaid redeterminations in the month. The file names are:

MEDS File: &<hlq>.vendor-ID.REVIEW.FILE and &<hlq>.vendor-ID.REVIEW.FILE.MCF

CURAMFile: &<hlq>.vendor-ID.REVIEWC.FILE and &<hlq>.vendor-ID.REVIEWC.FILE.MCF

Files are created after cutoff each month which is normally the third Thursday of the month; this typically falls between the 20th and 26th of the month.

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
1.	REV-FAMILY –NUMBER	8	1	8	C	Recipient identifying family number.
2.	Filler	1	9	9		
3.	REV-RECIP-NO	10	10	19	C	Recipient identifying Medicaid number.
4.	Filler	1	20	20		
5.	REV-RECIP-NAME	20	21	40	C	Recipient name, Last, First, Middle Initial
6.	Filler	1	41	41		
7.	REV-ADDR-STREET	25	42	66	C	
8.	Filler	1	67	67		
9.	REV-ADDR-CITY	20	68	87	C	
10.	Filler	1	88	88		
11.	REV-ADDR-STATE	2	89	90	C	
12.	Filler	1	91	91		
13.	REV-ADDR-ZIP	5	92	96	C	
14.	Filler	1	97	97		
15.	REV-ADDR-PHONE	15	98	112	C	
16.	Filler	1	113	113		

17.	REV-REVIEW-DATE	10	114	123	N	CCYY-MM-DD
18.	Filler	1	124	124		
19.	REV-REVIEW-MAILED	10	125	134	N	CCYY-MM-DD
20.	Filler	1	135	135		
21.	REV-PROVIDER-NO	6	136	141	C	
22.	Filler	1	142	142		
23.	REV-BOARD-PROV-NO	6	143	148	C	Applicable for medical home programs only
24.	Filler	1	149	149		
25.	REV-PAYEE-NAME	25	150	174	C	Name of payee for family
26.	Filler	1	175	175		
27.	REV-PAYEE-TYPE	3	176	178	C	Payee Type: See Note 1 below.
28.	Filler	1	179	179		
29.	REV-RECIP-PAY-CAT	2	180	181	C	Pay Categories: See Note 2 below.
30.	Filler	1	182	182		
31.	COUNTY-WORKER-FIRST-NAME	17	183	199	C	
32.	Filler	1	200	200		
33.	COUNTY-WORKER-LAST-NAME	26	201	226	C	
34.	Filler	1	227	227		
35.	COUNTY-WORKER-PHONE	10	228	237	C	
36.	Filler	1	238	238		
37.	COUNTY-WORKER-PHONE- EXTENSION	4	239	242	C	
38.	Filler	1	243	243	C	
39.	HOUSEHOLD NUMBER	9	244	252	C	Ties households together.
40.	Filler	48	253	300		

Special instruction:

1. All records must be fixed length.
2. Column N/C:
    a. N = Numeric – All numeric fields are right justified and zero filled to left
        i. EX: 5 bytes 123 will appear as 00123
    b. C = Character – All character fields are left justified and space filled to the right
    c. Unless otherwise specified there will be no signed fields

Logic for inclusion in this file is as follows:

WHERE BG.BG_CDE_STATUS = 'A'
AND BG.BG_CDE_ACTION = 'R'

AND ((BG.BG_DTE_FORM_MAILED <= CURRENT DATE - 30 DAYS) OR
(BG.BG_DTE_FORM_MAILED IS NULL))
AND BG.BG_DTE_FORM_RECD IS NULL
AND BG.BG_NUM_PYMT_CATEGORY IN ('12','15','16','17','18',
'19','32','40','57','59','71','88')
AND BG.BG_UID_WORKER_ID = WKR.WKR_UID_WORKER_ID
AND BG.BG_NUM_BUDGET_GROUP_ID = HB.HBJ_NUM_BUDGET_GROUP_ID AND
BG.BG_NUM_BUDGET_GROUP_ID = BMJ.BMJ_NUM_BUDGET_GROUP_ID AND
MEH.MEH_NUM_MEMBER_ID = BMJ.BMJ_NUM_MEMBER_ID
AND MEH.MEH_NUM_BUDGET_GROUP_ID = BMJ.BMJ_NUM_BUDGET_GROUP_ID
AND MEH.MEH_DTE_INELIG IS NULL
AND WKR.WKR_CDE_COUNTY = LOC.LOC_CDE_COUNTY
AND WKR.WKR_CDE_LOCATION = LOC.LOC_CDE_LOCATION

Note 1: Payee Types for Field 27

SEL SELF OR AFDC PAYEE GDN LEGAL GUARDIAN REL OTHER RELATIVE AGY SOCIAL AGENCY
PPP PROTECTIVE PAYEE
REP REPRESENTATIVE PAYEE FOS INDICATES FOSTER CHILD SPO SPOUSE
INP LEGALLY INCOMPETENT, NO REPRESENT

Note 1: Payment Categories for Field 29

10	MAO (NURSING HOMES)	52	SLMB (SPF LOW INC MEDCARE BENEFICIAR)
11	MAO (EXTENDED TRANSITIONAL)	53	NOT CURRENTLY BEING USED
12	OCWI (INFANTS UP TO AGE 1)	54	SSI NURSING HOMES
13	MAO (FOSTER CARE/SUBSIDIZED ADOPTION)	55	FAMILY PLANNING
14	MAO (GENERAL HOSPITAL)	56	COSY/ISCEDC
15	MAO (CLTC)	57	KATIE BECKETT CHILDREN - TEFRA
16	PASS-ALONG ELIGIBLES	58	FI-MAO (TEMP ASSIST FOR NEEDY)
17	EARLY WIDOWS/WIDOWERS	59	LOW INCOME FAMILIES
18	DISABLED WIDOWS/WIDOWERS	60	REGULAR FOSTER CARE
19	DISABLED ADULT CHILD	68	FI-MAO WORK SUPPLEMENTATION
20	PASS ALONG CHILDREN	70	REFUGEE ENTRANT
30	AFDC (FAMILY INDEPENDENCE)	71	BREAST AND CERVICAL CANCER
31	TITLE IV-E FOSTER CARE	80	SSI
32	AGED, BLIND, DISABLED	81	SSI WITH ESSENTIAL SPOUSE

33	ABD NURSING HOME	85	OPTIONAL SUPPLMENT
40	WORKING DISABLED	86	SUPPLEMENT & SSI
41	MEDICAID REINSTATEMENT	87	OCWI (PREGNANT)
48	S2 SLMB	88	OCWI (CHILD UP TO 19)
49	S3 SLMB	90	MEDICARE BENE(QMB)
50	QUALIFIED WORKING DISABLED (QWDI)	91	RIBICOFF CHILDREN
51	TITLE IV-E ADOPTION ASSISTANCE	92	ELIGIBLE FOR GAPS; NOT MEDICAID ELIGIBLE

Section 3.6: **Manual Maternity Kicker**

MCO maternity kicker payments for newborns enrolled in an MCO during the first three months of life will have the monthly automated maternity kicker payment calculated as part of the monthly automated/systemic capitation process.

For those cases where the MCO did not receive a maternity kicker payment through the automated/systemic process, and in cases where there is a stillborn birth, the MCO of the enrolled mother must submit the Manual Maternity Kicker reporting template found in the report companion guide and at the following location, in order to request payment.
https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

The MCO is expected to work with the eligibility team to obtain accurate and complete information on newborns when this information is not known to the MCO.

Requests for manual maternity kicker payments may only be made between the fourth and sixth month after birth. The table on the following page below indicates for each birth month, when the manual maternity kicker payments may be submitted. SCDHHS, at its discretion, may consider payments beyond this timeline.

Completed forms are to be uploaded to the Department's SharePoint site in the MCO's monthly libraries. Once uploaded to SharePoint the Department will review the submissions for appropriateness and submit a Gross Level Adjustment for any maternity kicker payments due to the MCO. A copy of the MCO's submitted Maternity Kicker Template will be returned to the MCO upon processing of the requests. Any payments made will be indicated on the form.

In order to be processed as a manual maternity kicker for newborns and stillborns, the form must be completed as follows:

1) In months one (1)- five (5):
   a) For newborns: All fields on the form must be completed for the mother AND the newborn. Entries that are incomplete will not be processed. The MCO will need to resubmit these entries in a subsequent acceptable period.
   b) For Stillborns: All fields on the form must be completed for the mother and the date of birth must be completed for the stillborn. Encounter records will be used to validate these deliveries.

2) In month six (6):
   a) For newborns: At a minimum, all fields for the mother must be completed and the child's date of birth and sex must be completed.

SCDHHS will review the accepted encounter transactions for the mother in month 6 when the newborn's name and Medicaid ID are not indicated on the maternity kicker payment notification log, searching for a diagnosis and/or a procedure code that indicates a delivery.

SCDHHS will process any maternity kicker reported in month 6 when SCDHHS reviewed encounter records confirm the delivery.

MANUAL MATERNITY KICKER REQUEST SCHEDULE			
BIRTH MONTH	**MK AUTO PAY MONTHS**	**MANUAL MK REQUEST MONTHS**	**MONTH REPORTS RECEIVED by SCDHHS**
January	January February March	April May June	May June July
February	February March April	May June July	June July August
March	March April May	June July August	July August September
April	April May June	July August September	August September October
May	May June July	August September October	September October November
June	June July August	September October November	October November December
July	July August September	October November December	November December January

August	August September October	November December January	December January February
September	September October November	December January February	January February March
October	October November December	January February March	February March April
November	November December January	February March April	March April May
December	December January February	March April May	April May June

Section 3.11: **Health Plan Initiated Member Disenrollment Form**

This form should be completed when a MCO is requesting member disenrollment. The form can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools

Section 3.17: Call Center Performance

This report is to be submitted to the MCO's monthly SharePoint library. The report should have three worksheets (tabs) to report the call center metrics for the member English line, member Spanish line, and the provider call center. The report template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

SECTION 4- CORE BENEFITS AND SERVICES

Section 4.2:

Universal Medication Prior Authorization Form

This form is utilized for providers requesting medications and can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools

Universal PA Form Synagis

Required for providers requesting Synagis, can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools.

Section 4.2: High Cost No Experience Drug Report

This form is utilized for requesting reimbursement of High Cost No Experience pharmaceuticals as defined in the MCO policy and procedure guide and can be found at https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp

If there are no records for a given month, submit the report with 'nothing to report' in the template. The report template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 4.2: Institution for Mental Disease (IMD)

For any member aged twenty-one (21) through sixty four (64) receiving inpatient treatment in an Institution for Mental Disease (IMD) the length of stay must not exceed 15 days in any month. A report of these instances will be provided by SCDHHS to the MCOs.

An example of how the report will appear may be found below.

Example: Institution for Mental Disease Report

Date:	
Report Requested By:	
Report Title:	
MCO Name:	

ANNUAL REPORT OF MEMBERS EXCEEDING 15 DAY STAYS IN IMD DURING THE FISCAL YEAR

Individual Number	Recipient First Name	Recipient Last Name	Date of Birth	MCO Name	MCO Number	Premium Month Exceeding 15 day IMD Stay	Total IMD Days in Month	Original Total Premium Paid	Original Paid Date	Prorated Premium Amount for Month Exceeding 15 days	Difference Between Original Premium Payment and Prorated Amount That Should Have Been Paid

DATA DEFINITIONS FOR IMD	
Descriptor	**Definition**
Individual Number	The individual Medicaid number of the member tied to the original premium payment issued by SCDHHS.
Recipient First Name	The first name of the Medicaid member that SCDHHS is performing the adjustment on.
Recipient Last Name	The last name of the Medicaid member that SCDHHS is performing the adjustment on.
Date of Birth	The birthdate of the member. IMD 15 day stay limitations apply to any member between the ages of 21 and 64, evaluated as the first day of the month.
MCO Name	The name of the Managed Care Organization.
MCO Number	The Medicaid legacy ID of the Managed Care Organization.
Premium Month Exceeding 15 Day IMD Stay	The month that the recipient overstayed the 15-day requirement.
Total IMD Days in Month	The total number of IMD admitted days in month.
Original Total Premium Paid	The total premium amount initially paid to the Managed Care Organization.
Original Paid Date	The date that the original premium was paid to the MCO.
Prorated Premium Amount for Month Exceeding 15 Days	The prorated premium amount that should have been paid because the member was identified as exceeding the 15-day stay in an IMD.
Difference Between Original Premium Payment and Prorated Amount That Should Have Been Paid	The difference between the actual amount that was paid and the prorated amount that should have paid for the member exceeding the 15-day IMD stay.

Section 4.3: Additional Services Request Form

If an MCO would like to request to provide additional services beyond the core benefit please complete the form found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Field definitions are provided below. MCO's are encouraged to add additional information as necessary to support their request.

The approved services are required to be saved on SharePoint under shared documents in the additional services folder with the following naming convention:

Plan Name – Additional Service –Name of Additional Service-YYYY

REQUIRED FIELDS FOR ADDITIONAL SERVICES EVALUATION	
Primary Sponsor	Requestor
Member Additional Service Request	Title/subject matter of this additional service request.
Request Submission Date	Date this request is submitted to SC DHHS.
Background and Rationale	Complete description of problem statement and reason for request, as well as rationale supporting the selection of this specific additional service.
Objectives	Statement of what the MCO is trying to accomplish with this additional service request.
Exploratory	Measurable outcomes that the MCO expects as a result of providing the additional service. What will the MCO measure to evaluate the efficacy of this intervention?
Duration of Study	Measurement period. (Start and end date of evaluation period.)
Comparator	Provide baseline data of all measurements described in the exploratory section with this request. At completion of the measurement period, the MCO must provide post-intervention performance data.
Subject Population/Comparator	The population that you are targeting for this intervention; please be specific. Examples include: Age grouping/dates of enrollment/ diagnoses/ procedural codes.
Cost	Provide cost information related to the service. If a card is being issued list the type, amount, what member must do to receive the card and verification process.
Ineligible Criteria	Define reasons why someone may be removed or ineligible for the service. *Example- Members who lose Medicaid eligibility for a period lasting longer than 90 days, or three (3) months.*
Is this a service discontinuation request	Provide an explanation as to why the plan is discontinuing the service from the MCO Plan benefit.

Example- Additional Services Request Form

MCO ADDITIONAL SERVICE REQUEST FORM

MCO Name: _____ **Date:** _____

Primary Sponsor	
Additional Services Request	
Request Submission Date	
Background and Rationale	
Objectives	
Exploratory	
Duration of Study	
Comparator	
Subject Population/Comparator	
Cost	
Ineligible Criteria	
Is this a Service Discontinuation Request?	

Plan certifies that this service complies with all state and federal laws and regulations.

Service Approved ____ Denied ____
DHHS Manager Name: _____ Date: _____

Discontinuation Approved ____ Denied ____
DHHS Manager Name: _____ Date: _____

Section 4.3 Additional Services Template

The Additional Services Template is a comprehensive list of all additional services and expanded benefits each MCO offers to its Managed Care Members. SCDHHS will be utilizing the Additional Services Template to assist in approving the final submission of the Expanded Benefits Chart.

A copy of the Additional Services Template may be found at https://www.scdhhs.gov/resources/health-managed-care-plans/managed-care-organizations-mco/managed-care-resources

Section 4.3 Expanded Benefits Chart

All approved requests of the Additional Services Template will be submitted to the Enrollment Broker (South Carolina Healthy Connections Choices) annually by SCDHHS and will be added to the Enrollment Broker's full list of expanded benefits among the different Managed Care plans.

A copy of the current list may be found at https://www.scchoices.com/Member/Step3PBECompare.aspx?frommenu=true

Section 4.2: Additional Services Evaluation Report

A copy of the Additional Services Evaluation Report template may be found at https://www.scdhhs.gov/resources/health-managed-care-plans/managed-care-organizations-mco/managed-care-resources

Example- Healthy Connections Choices, Expanded Benefits Chart Webpage

	Absolute Total Care	First Choice by Select Health of South Carolina	Healthy Blue by BlueChoice of SC	Humana Healthy Horizons™ in South Carolina	Molina Healthcare of SC
Details:	Details	Details	Details	Details	Details
Plan Type	MCO	MCO	MCO	MCO	MCO
Phone Number	1-866-433-6041	1-888-276-2020	1-866-781-5094	1-866-432-0001	1-855-882-3901
Website	www.AbsoluteTotalCare.com	www.selecthealthofsc.com	www.HealthyBlueSC.com	www.Humana.com/HealthySouthCarolina	www.molinahealthcare.com
How is your Health Plan Rated	★★★☆☆	★★★½☆	★★★½☆	★★★☆☆	★★★½☆
Counties Served	All SC Counties	All SC Counties	All SC Counties	All SC Counties	All SC Counties
			Additional Services		
Asthma Services	• Free asthma case management program		• Asthma Toolkit for qualifying members		• Free asthma education and care management program
Behavioral Health Services			• Learn to Live app for on-line therapy & support		
Cellular Services	• Free cell phone with monthly minutes, unlimited texts	• Free cell phone with monthly data and unlimited texts	• Free cell phone with monthly minutes, data, and texts	• Free cell phone with monthly minutes, data, and texts	• Free cell phone with monthly minutes, data, and texts
Education	• Reading Scholarship program, Pre-K through 5th grade • Free GED testing, age 16 and older	• GED vouchers for qualifying members • College scholarships for qualifying members • Free back-to-school events and supplies • Free community center with certified counselors, computer center, assistance with tax filing, resume writing, job searches, and more • Member appreciation events at local museums, and books for children	• Free tutoring services for K-8th • Free GED testing, ages 17 and older • Free Headset Learning Gear	• Free GED test and preparation services • Free online tutoring for grades K-12	• Free back-to-school events and supplies
Food Assistance		• Free home-delivered fresh produce boxes or meal kits for qualifying members	• Free home-delivered meals for qualifying members • Free Fresh Fruits and vegetables to qualifying members	• Free home-delivered meals for qualifying members • Free Baby and Me Meals for qualifying members • Free Fresh Fruits and vegetables to qualifying members	• Mom's Meals for qualifying moms • Thanksgiving events with food distribution
Housing Assistance	• Housing Assistance Coordinator	• FindHelp.org Resource	• Community Resource Link	• Assistance with services such as rent, mortgage utilities, and moving expenses for qualifying members	• Community Connectors to assist with housing needs/ resources
Over-the-Counter (OTC) Benefit	• Free OTC benefit for eligible items	• Free OTC benefit for eligible items • Free weather emergency kits/first aid supplies	• Free qualifying OTC drugs with prescription	• Free OTC benefit for eligible items	
Prenatal/ Postpartum Services	• Free electric breast pump	• Free electric breast pump	• Free electric breast pump	• Free electric breast pump	• Free electric breast pump
Smoking Cessation	• Free smoking cessation counseling and medications	• Free smoking counseling and medications	• Free smoking counseling and medications	• Free smoking counseling and medications	• Free smoking cessation counseling and medications
Vision Services		• Free adult vision, eye exams & glasses every 2 years	• Free adult vision, eye exams & glasses every 2 years	• Free adult vision, eye exams & glasses or contacts every 2 years	• Free adult vision, eye exams & glasses every 2 years

Section 4.8: Member Incentive Form

If an MCO would like to utilize a member incentive above $25.00, please complete the form found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

The MCO must email the completed form to the Marketing Specialist and must copy their respective MCO Plan Manager.

Approved/Denied forms will be uploaded by the Contract Monitor to the MCO's Shared Documents folder on SharePoint/Office 365.

Field definitions are provided below. MCO's are encouraged to add additional information as necessary to support their request.

The member incentives are required to be saved on SharePoint under shared documents in the member incentive folder with the following naming convention:

Plan Name – Member Incentive –Name of Member Incentive-YYYY

REQUIRED FIELDS FOR INCENTIVE EVALUATION	
Primary Sponsor	Requestor
Member Incentive Request	Title/subject matter of this request above $25.00 for unique study regarding member incentives.
Request Submission Date	Date this request is submitted to SC DHHS.
Background and Rationale	Complete description of problem statement and reason for request, as well as rationale supporting the selection of this specific incentive.
Objectives	Statement of what the MCO is trying to accomplish with this incentive request.
Exploratory	Measurable outcomes that the MCO expects as a result of providing the incentive. What will the MCO measure to evaluate the efficacy of this intervention?
Duration of Study	Measurement period. (Start and end date of evaluation period.)
Comparator	Provide baseline data of all measurements described in the exploratory section with this request. At completion of the measurement period, the MCO must provide post- intervention performance data.

Subject Population/Comparator	The population that you are targeting for this intervention.; please be specific. Examples include: Age grouping/dates of enrollment/ diagnoses/ procedural codes.
Cost	Provide cost information related to the service. If a card is being issued list the type, amount, what member must do to receive the card and verification process.
Ineligible Criteria	Define reasons why someone may be removed or ineligible for the service. *Example- Members who lose Medicaid eligibility for a period lasting longer than 90 days, or three (3) months.*
Is this a service discontinuation request	Provide an explanation as to why the plan is discontinuing the service from the MCO Plan benefit.

Example- MCO Member Incentive Request Form

MCO MEMBER INCENTIVE REQUEST FORM

MCO Name: _____ **Date:** _____

Primary Sponsor	
Additional Services Request	
Request Submission Date	
Background and Rationale	
Objectives	
Exploratory	
Duration of Study	
Comparator	
Subject Population/Comparator	
Cost	
Ineligible Criteria	
Is this a Service Discontinuation Request?	

Plan certifies that this service complies with all state and federal laws and regulations.

Service Approved ____ Denied ____
DHHS Manager Name: _____ Date: _____

Discontinuation Approved ____ Denied ____
DHHS Manager Name: _____ Date: _____

SECTION 5- CARE COORDINATION AND CASE MANAGEMENT

Section 5.4: Case Management Report: The MCO must submit the following report monthly to indicate its members currently receiving care management during the month. The report template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 5.5: Universal Newborn PA:

This form is available on the SCDHHS website at https://msp.scdhhs.gov/managedcare/site-page/reference-tools and is labeled Universal Newborn Prior Authorization Form. Providers need to complete this form in cases where a newborn is being seen out of network with an MCO. Please see the contract for additional details regarding newborn Medicaid services.

SECTION 6- NETWORKS

Section 6.3: Provider Network Report

This report must be submitted to SCDHHS quarterly and as requested by the Department. Below are instructions and definitions on the submission of the entire network to the Department. The template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Plan specific information	Plan Name	Required by SC DHHS
	Time Period	
	Record Added or Modified by MCO	
Information specific to the provider	Medicaid Provider ID	
	NPI of Provider	
	First Name	NCQA Standards for Network Management Net 6 Physician and Hospital Directories (Element A: Physician Directory)
	Middle Name	
	Last Name	
	Gender	
	Primary Specialty (Code)	
	Primary Specialty (Description)	
	Secondary Specialty (Code)	
	Secondary Specialty (Description)	
	Taxonomy Code for Primary Specialty	Required by SC DHHS
	Taxonomy Code for Secondary Specialty	
	Group Name	
	Group Federal Employee ID Number	
	Provider License Number	
	Provider Email Address	
	Age Range Served	
	Hospital Affiliation 1	

Provider Hospital Affiliations (add more columns if needed)	Hospital Affiliation 2	
	Hospital Affiliation 3	
Provider Office Locations (Add a new record for each location)	Primary Location (Y/N)	
	Practice Name	NCQA Standards for Network Management Net 6 Physician and Hospital Directories (Element A: Physician Directory)
	Address	
	Suite/Building	
	City	
	State	
	ZIP	
	Phone Number	
Provider Office Information	Ownership of Practice (Hospital Name, Group Name, Organization Name, Sole Proprietorship)	Required by SC DHHS
	Provider Office Website Address	
	Average Number of Patients Seen Per Day	
	Accepting New Medicaid Patients	NCQA
	Office Hours (Sunday – Saturday)	
	Languages Spoken by Physician or Clinical Staff	
	Handicapped Accessible	
	Patient Centered Medical Home (PCMH) Recognition Level	Required by SC DHHS

Data Definitions for Provider Network Report	
Descriptor	**Definition**
Plan Name	Name of MCO submitting the data to SCDHHS
Time Period	When the report was generated by the reporting entity.
Record Added or Modified by MCO	If you change data in the record that was provided, please indicate the following: • A- Record was added by the MCO and is a new record not in the original file. • M- Data element(s) on the record have been modified from the original file. • N- No change to the original file record. For the initial submission please use A in all entries.
Medicaid Provider ID	The six digit Medicaid ID issued to the provider by SCDHHS.
NPI of Provider	The national provider ID of the provider issued by NPPES.
First Name	The provider's first name.
Middle Name	The provider's middle name.
Last Name	The provider's last name.
Gender	The provider's gender, F-Female, M-Male
Primary Specialty (Code)	The specialty code utilized by the MCO to describe the specialty of the individual provider.
Primary Specialty (Description)	The description of the code utilized by the MCO to describe the provider specialty.
Secondary Specialty (Code)	The specialty code utilized by the MCO to describe the secondary specialty of the provider.
Secondary Specialty (Description)	The description of the code utilized by the MCO to describe the provider secondary specialty.
Taxonomy Code for Primary Specialty	The taxonomy code of the provider found at NPPES.
Taxonomy Code for Secondary Specialty	If applicable, the secondary specialty taxonomy code of the provider found at NPPES.

Group Name	The name of the provider that coincides with the Federal Employee ID number found in the next column.
Group Federal Employee ID Number	This field must be completed for all providers. If the provider being listed is an individual provider, the federal tax identification number of the practice he/she is associated with should be listed in this data field. If the individual is associated with multiple practices/ groups the individual provider should be listed they are associated with. For example, if Dr. Smith is associated with ACME Providers 1 (tax ID:1234) and ACME Providers 2 (tax ID: 5678) Dr. Smith will be listed twice on the report once with tax ID:1234 and once with tax ID: 5678 For each provider practice/group, the MCO must indicate the federal tax identification number of the practice/group once.
Provider License Number	If applicable, the license number of the provider.
Provider Email Address	The email address of the provider.
Age Range Served	The age range of patients served by the provider expressed in years. *For example, Joe's orthopedics would be expressed 0-100 if the practice serves any age member.*
Hospital Affiliation 1	The primary hospital the individual provider is affiliated with and routinely admits Medicaid members to for treatment.
Hospital Affiliation 2	The secondary hospital the individual provider is affiliated with and admits Medicaid members to for treatment.
Hospital Affiliation 3	The tertiary hospital the individual provider is affiliated with and admits Medicaid members to for treatment.
Primary Location	Please indicate if the location listed is the provider's primary practice location. Values are Y/N, where Y indicates that this record is the primary location.
Practice Name	The name of the practice where the provider is located and may provide services.
Address	The physical address location of the practice where the provider is located and may provide services.
Suite/Building	If applicable, the suite or building number where the provider is located and may provide services.

City	The physical location city of the practice where the provider is located and may provide services. • State: The physical location state of the practice where the provider is located and may provide services. • Zip: The physical location zip code of the practice where the provider is located and may provide services.
Phone Number	The phone number of the primary location practice where the provider is located and may provide services.
Ownership of Practice	Please indicate who holds ownership of the practice. If the practice is owned by a hospital indicate the hospital that owns the practice. If owned by a group or an organization other than a hospital indicate the organization or group's name. If owned by a sole proprietor, please indicate sole proprietor in this field. NOTE: A standardized list of hospitals has been provided in *Exhibit 1** below. Please use this list to add hospital names.
Provider Office Website Address	If the provider has a website, the website address of the provider.
Average Number of Patients Seen Per Day	The average number of patients seen per day. Please take the number of patients seen by the practice in the last month and divide that total by 20 (average number of business days in the month). *For example, if the practice saw 700 patients over the past month the average number of patients seen per business day is 35.* If the value expressed is fractional, please truncate the fractional value.
Accepting New Medicaid Patients	Is the provider accepting new Medicaid patients? Please see *Exhibit 2*** below that describe the type of new patient values.
Office Hours (Sunday- Saturday)	These are the operating hours of the group. Please include office hours for each day of the week and include any breaks for lunch in this field.
Languages Spoken by Provider or Staff	Indicate the languages spoken by the physician or their clinical staff. If left blank this indicates provider speaks English only. If the provider speaks several languages this must be represented by inserting all languages in this field separating each language spoken with a comma followed by a space and then the next language spoken (E.G.: SPA, ENG, FRE, POR, GER). Please see *Exhibit 3**** for a list of codes.
Handicap Accessible	Is the provider's office handicap accessible? Add Y for yes if it is handicap accessible; add N for No if it is not handicap accessible.

Patient Centered Medical Home (PCMH) Recognition Level	If the provider has PCMH recognition, please indicate the level of recognition obtained by the provider through the National Committee for Quality Assurance (NCQA).

Exhibit 1- Standardized List of Hospitals in South Carolina

KEY	HOSPITAL NAME	ADDRESS	CITY	STATE	ZIP
1	Abbeville Area Medical Center	420 Thomson Cir	Abbeville	SC	29620-5656
2	Aiken Regional Medical Centers	302 University Pkwy	Aiken	SC	29801-6302
3	Allendale County Hospital	1787 Allendale Fairfax Hwy	Fairfax	SC	29827-9133
4	AnMed Behavioral Health	2000 E Greenville St	Anderson	SC	29621-1580
5	AnMed Health Cannon	123 Wg Acker Dr	Pickens	SC	29671-2739
6	AnMed Health Medical Center	800 N Fant St	Anderson	SC	29621-5793
7	AnMed Health Rehabilitation Hospital	1 Spring Back Way	Anderson	SC	29621-2676
8	Beaufort Memorial Hospital	955 Ribaut Rd	Beaufort	SC	29902-5454
9	Bon Secours-St Francis Xavier Hospital	2095 Henry Tecklenburg Dr	Charleston	SC	29414-5734
10	Carolina Center For Behavioral Health	2700 E Phillips Rd	Greer	SC	29650-4815
11	Carolina Pines Regional Medical Center	1304 W Bobo Newsom Hwy	Hartsville	SC	29550-4399
12	Cherokee Medical Center	1530 N Limestone St	Gaffney	SC	29340-4738
13	Coastal Carolina Hospital	1000 Medical Center Dr	Hardeeville	SC	29927-3446
14	Colleton Medical Center	501 Robertson Blvd	Walterboro	SC	29488-5714
15	Conway Medical Center	300 Singleton Ridge Rd	Conway	SC	29526-9142
16	East Cooper Medical Center	2000 Hospital Dr	Mount Pleasant	SC	29464-3764
17	Edgefield County Healthcare	300 Ridge Medical Plaza Rd, Ridge Medical Plaza	Edgefield	SC	29824-4525
18	Encompass Health Rehabilitation Hospital of Columbia	2935 Colonial Dr	Columbia	SC	29203-6811
19	Encompass Health Rehabilitation Hospital of Florence	900 E Cheves St	Florence	SC	29506-2704
20	Encompass Health Rehabilitation Hospital of Rock Hill	1795 Dr Frank Gaston Blvd	Rock Hill	SC	29732-1190
21	G Werber Bryan Psychiatric Hospital	220 Faison Dr	Columbia	SC	29203-3210

22	Grand Strand Medical Center	809 82nd Pkwy	Myrtle Beach	SC	29572-4611
23	Greenwood Regional Rehabilitation Hospital	1530 Pkwy	Greenwood	SC	29646-4027
24	Hampton Regional Medical Center	595 W Carolina Ave	Varnville	SC	29944-4735
25	Hilton Head Hospital	25 Hospital Center Blvd	Hilton Head Island	SC	29926-2738
26	Lexington Medical Center	2720 Sunset Blvd	West Columbia	SC	29169-4810
27	Lighthouse Behavioral Health Hospital	152 Waccamaw Medical Park Dr	Conway	SC	29526-8901
28	McCleod Health Cheraw	711 Chesterfield Hwy	Cheraw	SC	29520-7002
29	Mcleod Health Clarendon	10 E Hospital St	Manning	SC	29102-3153
30	Mcleod Health Loris	3655 Mitchell St	Loris	SC	29569-2844
31	Mcleod Health Seacoast	4000 Hwy 9 E	Little River	SC	29566-7833
32	Mcleod Medical Center Dillon	301 E Jackson St	Dillon	SC	29536-2509
33	Mcleod Regional Medical Center Of The Pee Dee	555 E Cheves St	Florence	SC	29506-2617
34	Morris Village	610 Faison Dr	Columbia	SC	29203-3218
35	MUSC Health Columbia Medical Center Downtown	2435 Forest Dr	Columbia	SC	29204-2098
36	MUSC Health Florence Medical Center	805 Pamplico Hwy	Florence	SC	29505-6050
37	MUSC Health Kershaw Medical Center	1315 Roberts St	Camden	SC	29020-3737
38	MUSC Health Lancaster Medical Center	800 W Meeting St	Lancaster	SC	29720-2298
39	MUSC Health Rehabilitation Hospital	9181 Medcom St	Charleston	SC	29406-9184
40	MUSC Healthy Marion Medical Center	2829 E Hwy 76	Mullins	SC	29574-6035
41	MUSC Medical Center	169 Ashley Ave	Charleston	SC	29425-8905
42	Newberry County Memorial Hospital	2669 Kinard St	Newberry	SC	29108-2932
43	Palmetto Health Baptist	1330 Taylor St	Columbia	SC	29220
44	Palmetto Health Baptist Parkridge	400 Palmetto Health Pkwy	Columbia	SC	29212-1760
45	Palmetto Lowcountry Behavioral Health	2777 Speissegger Dr	North Charleston	SC	29405-8229
46	Patrick B Harris Psychiatric Hospital	130 Hwy 252	Anderson	SC	29621-5054
47	Pelham Medical Center	250 Westmoreland Rd	Greer	SC	29651-9013
48	Piedmont Medical Center	222 S Herlong Ave	Rock Hill	SC	29732-1158

49	Prisma Health Baptist Easley Hospital	200 Fleetwood Dr	Easley	SC	29640-2099
50	Prisma Health Baptist Hospital	1330 Taylor St	Columbia	SC	29220
51	Prisma Health Greenville Memorial Hospital	701 Grove Rd	Greenville	SC	29605-5611
52	Prisma Health Greer Memorial Hospital	830 S Buncombe Rd	Greer	SC	29650-2400
53	Prisma Health Hilcreast Hospital	729 Se Main St	Simpsonville	SC	29681-3280
54	Prisma Health Laurens County Hospital	22725 Hwy 76 E	Clinton	SC	29325-7527
55	Prisma Health North Greenville Hospital	807 N Main St	Travelers Rest	SC	29690-1598
56	Prisma Health Oconee Memorial Hospital	298 Memorial Dr	Seneca	SC	29672-9443
57	Prisma Health Patewood Hospital	175 Patewood Dr	Greenville	SC	29615-3570
58	Prisma Health Richland Hospital	5 Richland Medical Park Dr	Columbia	SC	29203-6897
59	Prisma Health Tuomey Hospital	129 N Washington St	Sumter	SC	29150-4983
60	Providence Health - Northeast	120 Gateway Corporate Blvd	Columbia	SC	29203-9611
61	Rebound Behavioral Health	134 E Rebound Rd	Lancaster	SC	29720-7712
62	Regional Medical Center Of Orangeburg & Calhoun Counties	3000 Saint Matthews Rd	Orangeburg	SC	29118-1496
63	Roper Hospital	316 Calhoun St	Charleston	SC	29401-1125
64	Roper St. Fracis Mount Pleasant Hospital	3500 Hwy 17 N	Mount Pleasant	SC	29466-9123
65	Self-Regional Healthcare	1325 Spring St	Greenwood	SC	29646-3875
66	Shriners' Hospital For Children	950 W Faris Rd	Greenville	SC	29605-4277
67	Spartanburg Hospital For Restorative Care	389 Serpentine Dr	Spartanburg	SC	29303-3074
68	Spartanburg Medical Center Church Street Campus	101 E Wood St	Spartanburg	SC	29303-3072
69	Spartanburg Medical Center Mary Black Campus	1700 Skylyn Dr	Spartanburg	SC	29307-1061
70	Spartanburg Rehabilitation Institute	160 Harold Fleming Ct	Spartanburg	SC	29303-4226
71	Springbrook Behavioral Health System	1 Havenwood Ln	Travelers Rest	SC	29690-9447
72	St Francis-Downtown	1 Saint Francis Dr	Greenville	SC	29601-3999
73	St Francis-Eastside	125 Commonwealth Dr	Greenville	SC	29615-4812
74	Summerville Medical Center	295 Midland Pkwy	Summerville	SC	29485-8104
75	Three Rivers Behavioral Health	2900 Sunset Blvd	West Columbia	SC	29169-3422

76	Tidelands Georgetown Memorial Hospital	606 Black River Rd	Georgetown	SC	29440-3368
77	Tidelands Waccamaw Community Hospital	4070 Hwy 17 Bypass	Murrells Inlet	SC	29576-5033
78	Tri-County Commission on Alcohol and Drug Abuse	910 Cook Rd	Orangeburg	SC	29118-2124
79	Trident Medical Center	9330 Medical Plaza Dr	N Charleston	SC	29406-9104
80	Union Medical Center	322 W South St	Union	SC	29379-2839
81	Vibra Hospital of Charleston	1200 Hospital Dr	Mount Pleasant	SC	29464-3251
As Of June 2024,					
Reference Source: South Carolina Hospital Association					

Exhibit 2- New Patient Values

This code indicates how PSI will accept Enrollments to the Provider

Value	Description	Allow Choice Via			Patient Indicator
		Member Choice	Auto Assign	Family Assigned*	
1	Accepts All	Yes	Yes	N/A	No
2	Accepts None	No	No	No	Yes
3	Member Choice Only	Yes	No	N/A	No
4	Member Choice / Family	Yes	No	Yes	No
5	Auto Assign / Family	No	Yes	Yes	No
6	Auto Assign Only	No	Yes	N/A	No
7	Family Assign Only	Yes	Yes	Yes	No

* Family Assigned method is used when another member of the family already has this PCP Provider. If N/A, then Family Assigned is not taken into account. If Yes, then the Member must already have a family member enrolled. If No, then the Member does not have a family member enrolled.

Explanation of the 'New patient Indicator' values

- Accepts All: This is the default value for the new patient indicator. If the value is 1 for this field then this provider accepts new member choices as well as new auto assigned members. There is no restriction on the selections.

- Accepts None: The provider does not accept new members either through member selections or by auto assignments.

- Member Choice Only: The provider only accepts selections made by member choice. The provider does not accept any auto assigned members.

- Member Choice with Family: The provider accepts only selections by member choice only if a member of the family is already enrolled with the provider. The provider does not accept any auto assignments.

- Auto assignment with Family: The provider accepts only auto assignments if a member of the family is already enrolled with the provider. The provider does not accept any member choices. This is an unlikely scenario, but has been added as a choice for future changes.

- Auto assignment only: The provider only accepts auto assigned members. The provider does not accept any selections made by member choice. This is an unlikely scenario but has been added as a choice for future changes.

- Family Assign Only: The provider accepts both auto assigned members and member choices only if a member of the family is already enrolled with the provider.

Exhibit 3- Language Codes List

DHHS	Code	Language		DHHS	Code	Language
S	SPA	Spanish		L	LAO	Laotian
M	MDR	Mandarin		N	HMN	Hmung
P	POR	Portuguese		O	Oth	Other
V	VIE	Vietnamese		Q	GER	German
H	HIN	Hindi		U	UKR	Ukranian
K	KOR	Korean		W	ARM	Armenian
C	CHI	Chinese		X	KHM	Khmer
G	GUJ	Gujarati		Y	YID	Yiddish
R	RUS	Russian		Z	GRE	Greek
A	ARA	Arabic		1	SMO	Samoan
T	TUR	Turkish		2	HAT	Haitian
B	POL	Polish		3	SGN	American Sign Language
D	PER	Persian		4	TGL	Tagalog
F	FRE	French		5	NED	Nederland
I	ITA	Italian		6	EGY	Egyptian
J	JPN	Japanese			ALBA	Albanian
	AFR	Afrikanns			AMH	Amharic

	BEN	Bengali			BUL	Bulgarian
	CAM	Cambodian			CAN	Cantonese
	CRE	Creole			CRO	Croatian
	CZEC	Czechoslovakian			DUTC	Dutch
	EST	Estonian			ETH	Ethopian
	FAN	Fante			FAR	Farsi
	GUI	Guiarati			HA	Hausa
	HEB	Hebrew			IBO	Ibo
	HUN	Hungarian			ICE	Iceland
	IND	Indian			INDO	Indonesian
	KAN	Kannada			LAT	Latino
	LEB	Lebanese			LIT	Lithuanian
	MAL	Malayalam			MALA	Malay
	MAR	Marathi			NE	Nepali
	NO	Norwegian			PASH	Pashtou
	PHIL	Phillipino			PUN	Punjabi
	ROM	Romanian			SER	Serbian
	SIN	Sindhi			SLOV	Slovakian
	SOMA	Somali			SWA	Swahili
	SWE	Swedish			TAI	Taiwanese
	TAM	Tamil			TEL	Telugu
	THAI	Thai			URDU	Urdu
	YOR	Yoruba			ZUL	Zulu

SECTION 7- PAYMENTS

Section 7.2: Medical Loss Ratio Calculation

In January of each year SCDHHS will provide instructions and templates for completing Medical Loss Ratio reports due to the department in April.

Section 7.3: Premium Payment Adjustments

The following report will be sent to MCO's to retroactively reconcile premiums paid at a previously approved rate in months where a new premium has been created for payment but not yet implemented within the Medicaid processing system. An example of the report may be found below:

Example: Premium Payment Adjustments Report

South Carolina							
Department of Health and Human Services							
Bureau of Reimbursement Methodology and Policy							
Rate Adjustment Analysis							
Member Months							
Reporting for (date)							
							Adjusted
							Capitated
Rate Category		**Month**	**Total**	**Previous Rates**	**Present Rates**	**Variance**	**Payments**
0-2 months old	AH3						
3-12 months old	AI3						
1-6 M&F	AB3						

7-13 M&F	AC3						
14-18 M	AD1						
14-18 F	AD2						
19-44 M	AE1						
19-44 F	AE2						
45+ M&F	AF3						
Maternity Kicker any age	NG2						
SSI w/o Medicare (0-18)	SO3						
SSI w/o Medicare (19-up)	SP3						
OCWI F	WG2						
Foster Care	FG3						
Total Retro Rate Adj		0	0				0.00
Total Adjustment							
	File:				Date:		
	Subfile:				Prepared:		
	Path:				Reviewed:		
	Source:						

Section 7.3: Monthly Premium Recoupment

The MCO will receive this file on a monthly basis and will include a list of all members that received premium payment in error. It will have three sections and will include all members that have passed away (deceased members), members receiving waiver or hospice services, or members who possess duplicate Medicaid IDs. SCDHHS will perform premium voids that will appear on the 820 file for all members in this report to accurately pay premiums.

An example of how these reports will appear may be found below:

Example: Monthly Premium Recoupment Reports

DECEASED MEMBERS

Office of Reporting

Date:

Report Requested by:

Report Title:

Medicaid Id	First Name	Mi	Last Name	Date Of Death	Premium Date	Rate Cell	Rate Description	Claim Id	Provider Id	Provider Name	Check Date	Paid Date	Adj Type Code	Adjustment Description	Capitation Amount Paid	Internal Reason Code

Managed Care Members Retro-Terminated Entering a Waiver or Hospice Services

Medicaid ID	First Name	Last Name	Premium Date	Rate Cell	Premium Month	Claim ID	Provider ID	Provider Name	Payment Date	Check Date	Amount Paid	Managed Care Term Date	Reason for Termination from Managed Care	Internal Reason Code

Managed Care Members with Duplicate IDs and Premium Payments

Medicaid ID	First Name	Last Name	Premium Date	Rate Cell	Premium Month	Claim ID	Provider ID	Provider Name	Payment Date	Check Date	Amount Paid	Internal Reason Code

Data Definitions Deceased Member Recoupment Reporting

Descriptor	Definition
Medicaid ID	The individual Medicaid number of the member tied to the original premium payment issued by SCDHHS.
First Name	The first name of the Medicaid member that SCDHHS is performing the adjustment on.
MI	The middle initial of the Medicaid member that SCDHHS is performing the adjustment on.
Last Name	The last name of the Medicaid member that SCDHHS is performing the adjustment on.
Date of Death	The date that the member passed away.
Premium Date	The premium month. The month SCDHHS was making a premium payment for the member.
Rate Cell	The three character premium descriptor for the premium amount originally paid to the MCO.
Rate Description	The definition of the three (3) character premium description for the premium amount originally paid to the MCO.
Claim ID	Claim Control Number, the unique eighteen (18) character number assigned by SCDHHS to the original premium payment made to the Managed Care Organization.
Provider ID	The Medicaid legacy ID of the Managed Care Organization.
Provider Name	The name of the Managed Care Organization.
Check Date	The remittance date of the premium paid to the MCO.
Paid Date	The date that SCDHHS paid the premium to the MCO.
Adj Type Code	An internal code that defines the status of the premium. This value will be O in all instances on the report.
Adjustment Description	This is the definition of the Adj Type code. This value will be Original in all instances on the report.
Capitation Amount Paid	The total premium amount originally paid to the MCO.
Internal Reason Code	Utilized exclusively by SCDHHS for internal reporting.

Data Definitions Waiver Hospice Termination Recoupment Report

Descriptor	Definition
Medicaid ID	The individual Medicaid number of the member tied to the original premium payment issued by SCDHHS.
First Name	The first name of the Medicaid member that SCDHHS is performing the adjustment on.
Last Name	The last name of the Medicaid member that SCDHHS is performing the adjustment on.
Premium Date	The premium month. The month SCDHHS was making a premium payment for the member.
Rate Cell	The three character premium descriptor for the premium amount originally paid to the MCO.
Premium Month	The premium month. The month SCDHHS was making a premium payment for the member.
Claim ID	Claim Control Number, the unique eighteen (18) character number assigned by SCDHHS to the original premium payment made to the Managed Care Organization.
Provider ID	The Medicaid legacy ID of the Managed Care Organization.
Provider Name	The name of the Managed Care Organization.
Payment Date	The date that SCDHHS paid the premium to the MCO.
Check Date	The remittance date of the premium paid to the MCO.
Amount Paid	The total premium amount originally paid to the MCO.
Managed Care Term Date	The date that SCDHHS terminated the member from managed care enrollment due to waiver or hospice enrollment.
Reason for Termination from Managed Care	Field indicates whether the termination was due to WVR- waiver enrollment or HSP-Hospice enrollment.
Internal Reason Code	Utilized exclusively by SCDHHS for internal reporting.

Data Definitions for Duplicate Member Recoupment Report	
Descriptor	**Definition**
Medicaid ID	The individual Medicaid number of the member tied to the original premium payment issued by SCDHHS.
First Name	The first name of the Medicaid member that SCDHHS is performing the adjustment on.
Last Name	The last name of the Medicaid member that SCDHHS is performing the adjustment on.
Premium Date	The premium month. The month SCDHHS was making a premium payment for the member.
Rate Cell	The three character premium descriptor for the premium amount originally paid to the MCO.
Premium Month	The premium month. The month SCDHHS was making a premium payment for the member.
Claim ID	Claim Control Number, the unique eighteen (18) character number assigned by SCDHHS to the original premium payment made to the Managed Care Organization.
Provider ID	The Medicaid legacy ID of the Managed Care Organization.
Provider Name	The name of the Managed Care Organization.
Payment Date	The date that SCDHHS paid the premium to the MCO.
Check Date	The remittance date of the premium paid to the MCO.
Amount Paid	The total premium amount originally paid to the MCO.
Internal Reason Code	Utilized exclusively by SCDHHS for internal reporting.

Section 7.3: Dual Medicare/Medicaid Report

The MCO will receive this file on a monthly basis which will include all members that received retro-active Medicare eligibility during the month. SCDHHS will perform gross-level adjustments to the MCO monthly for all members in this report to accurately pay premiums up to a year in arrears.

An example of how this report shall appear may be found below:

Example: Dual Medicare/Medicaid Report

Office of Reporting															
Date:															
Report Requested by:															
Report Title:															
CCN	**Check Date**	**Check Number**	**Individual Number**	**MBI Number**	**Premium Month**	**Provider Name**	**Provider Number**	**Total Claim Charge**	**Total Amt. Paid per Claim**	**Amount That Should Have Paid Initially**	**Difference Between Actual Amount That Should Have Paid and Original Payment**	**Paid Date**	**Premium Date**	**Recipient First Name**	**Recipient Last Name**

Data Definitions for Duals Report

Descriptor	Definition
CCN	Claim Control Number, the unique eighteen (18) character number assigned by SCDHHS to the original premium payment made to the Managed Care Organization.
Check Date	The date that the check for the original premium payment was issued by SCDHHS.
Check Number	The number of the check for the original premium payment issued by SCDHHS.
Individual Number	The individual Medicaid number of the member tied to the original premium payment issued by SCDHHS.
MBI Number	The Medicare Beneficiary Indicator of the member. Medicare issued ID number.
Premium Month	The month that SCDHHS was making a premium payment for the member.
Provider Name	The name of the Managed Care Organization.
Provider Number	The Medicaid legacy ID of the Managed Care Organization.
Total Claim Charge	The total premium amount tied to the claim control number.
Total Amt. Paid per Claim	The total premium amount initially paid to the Managed Care Organization.
Amount That Should Have Paid Initially	The amount that should have been paid because the member was identified as retroactively eligible for Medicare services. This rate can be found in the MCO rate book and is reassessed on an annual basis.
Difference Between Actual Amounts That Should Have Paid and Original Payment	The difference between the actual amount that should have been paid, and the original premium payment made for the member.
Paid Date	The Date that the original premium was paid to the MCO.
Premium Date	The premium month. The month SCDHHS was making a premium payment for the member.
Recipient First Name	The first name of the Medicaid member that SCDHHS is performing the adjustment on.
Recipient Last Name	The last name of the Medicaid member that SCDHHS is performing the adjustment on.

Section 7.3: Patient Centered Medical Home (PCMH)

Completing the PCMH Form:

There are four (4) worksheet tabs to this report. Worksheet one (1) is a review of the instructions. With respect to worksheets two (2) through four (4), please note that as of the 2017 version of NCQA's PCMH Recognition standards, NCQA no longer uses a leveling system for its PCMH Recognition program; however, some practices continue to be recognized under older versions of PCMH Recognition standards (e.g. the 2014 version of NCQA's PCMH Recognition standards. For purposes of the PCMH incentive, NCQA PCMH Recognition under the 2017 version of NCQA's standards is equivalent to a Level III under older versions of the PCMH Recognition standards.

Worksheet two (2) is utilized for level 1 PCMH providers, worksheet three (3) is for the level 2 PCMH providers, and worksheet four (4) is for both the level 3 PCMH providers and any providers recognized under NCQA PCMH Recognition standards as of 2017 or later.

These reports should be submitted monthly to ensure that SCDHHS and its contractor can reimburse the plans' timely and accurately at the end of the quarter.

The report template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Example: Model Attestation Letter for Patient Centered Medical Home and Encounter Data

<Company Letter Head> Attestation for Reports

Date

I, <Name>, as <Title> for <Name of Company>, do hereby attest, based upon my best knowledge, information and belief, that the data provided in the encounters and Patient Centered Medical Home Report are accurate, true, and complete.

I understand that should SCDHHS determine the submitted information is inaccurate, untrue, or incomplete, <Name of company> may be subject to liquidated damages, sanctions and/or fines as outlined in Section 18 of the contract.

_____ _____

Signature/Title

Section 7.3: MCO Withhold Report

This report format is utilized for indicating withholds that SCDHHS initiates at the end of a reporting quarter as a component of its quality program. An example of the report can be found below:

Example: MCO Withold Report Format

South Carolina

Department of Health and Human Services

Withhold Calculation

MCO Name

Member Months

Rate Category		Month 1	Month 2	Month 3	Total	Rate w/o STP	Risk Adj	With-hold Rate	Withhold Total
0-2 months old	AH3							0.00	0.00
3-12 months old	AI3							0.00	0.00
1-6 M&F	AB3							0.00	0.00
7-13 M&F	AC3							0.00	0.00
14-18 M	AD1							0.00	0.00
14-18 F	AD2							0.00	0.00
19-44 M	AE1							0.00	0.00
19-44 F	AE2							0.00	0.00
45+ M&F	AF3							0.00	0.00
Foster Care any age M&F	FG3							0.00	0.00
Maternity Kicker any age	NG2							0.00	0.00
SSI w/o Medicare (0-18)	SO3							0.00	0.00
SSI w/o Medicare (19-up)	SP3							0.00	0.00
OCWI F	WG2							0.00	0.00
		0	0	0	0				0.00
Total Withhold									0.00

Section 7.4: FQHC/RHC Wrap Payments

Encounter/Claims Detail Data are provided in a separate file in MS Excel file format. All paid and denied claims for each FQHC/RHC contracting with the MCO during a specified quarter, by dates of service, are provided to SCDHHS via the Extranet, 60 days from the quarter's end date. The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 7.4: FQHC/RHC Summary Annual Reconciliation

Please upload this report to the MCO's annual library in SharePoint. See the specific required format for this report at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 7.9: Annual Audited Financial Statement

The annual audited financial statement is due July 1st of each year. This statement should be the same report that is produced by each MCO for the South Carolina Department of Insurance and should comply with the documents and format listed in Appendix A.

SECTION 9- GRIEVANCE AND APPEAL PROCEDURES & PROVIDER DISPUTES

Section 9.1: Member Grievance and Appeal Log

Grievance and Appeal reporting required of the MCO. This report is collected monthly and reported quarterly to SCDHHS.

The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 9.2: Provider Dispute Log

Provider Dispute Log required of the MCO. This report is collected monthly and reported quarterly to SCDHHS.

The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

SECTION 10- THIRD PARTY LIABILITY

Section 10.9: Third Party Liability Reports (TPL)

MCOs must submit Five (5) Monthly Reports, as described below:

1) TPL Verification

MCO report required for verification of Medicaid members identified as having TPL coverage that SCDHHS has not identified as having TPL coverage. This report is submitted via the Department's FTP site.

2) TPL Cost Avoidance

TPL refers to other health insurance, not Medicare. Do not include Medicare provider file encounters in this report.

a) Tab 1 -- TPL Cost Avoidance (Professional CMS-1500): MCO report required for claims cost avoided during the month for professional services. Provide a total for columns "charge" and "amount cost avoided".

b) Tab 2 -- TPL Cost Avoidance (UB Claims): MCO report required for claims cost avoided during the month for institutional services. Provide a total for columns "charge" and "amount cost avoided".

c) Tab 3 -- TPL Cost Avoidance (Drug Claims): MCO report required for claims cost avoided during the month for pharmacy services. Provide a total for columns "drug submit charge" and "amount cost avoided".

3) TPL Coordination of Benefits (COB) Savings

TPL refers to other health insurance, not Medicare. Do not include Medicare encounters in this report.

a) Tab 1 -- TPL Coordination of Benefits Savings (Professional Claims): MCO report required for claims where savings were realized through partial payment by a third-party insurer during the month for professional services. Provide a total for columns "claim charge", "primary health insurance payment", and "MCO claim paid amount".

b) Tab 2 -- TPL Coordination of Benefits Savings (UB Claims): MCO report required for claims where savings were realized through partial payment by a third-party insurer during the month for institutional services. Provide a total for columns "claim charge", "primary health insurance payment", and "MCO claim paid amount".

c) Tab 3 -- TPL Coordination of Benefits Savings (Drug Claims): MCO report required for claims where savings were realized through partial payment by a third-party insurer

during the month for pharmacy services. Provide a total for columns “drug submit charge”, “primary health insurance payment”, and “MCO claim paid amount”.

4) TPL Recoveries

TPL refers to other health insurance, not Medicare. Do not include Medicare encounters in this report. MCO report required for claims that were recovered during the month due to third party insurance coverage.

5) TPL Casualty Cases

MCO report required for any casualty cases that the MCO is aware of during the month.

a) Tab 1 – Open Casualty Cases: A list of the MCO’s Open Casualty Cases.

b) Tab 2 – Closed Casualty Cases: A list of the MCO’s Closed Casualty Cases,

c) Tab 3 – Casualty Case Alerts: A list of the MCO’s Casualty Case Alerts.

**The TPL Cost Avoidance, COB, Recoveries, and Casualty Cases reports can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

SECTION 11- PROGRAM INTEGRITY

Section 11.1: Provider Fraud Referral Form

MCO should send when they suspect provider fraud. The instructions and template can be found at the PI SharePoint site.

Section 11.1: Member Fraud and Abuse Referral Form

MCO should send when they suspect member fraud and abuse. The instructions and template can be found at the PI SharePoint site.

Section 11.1: BEOMB Notification Form

Beneficiary Explanation of Medicaid Benefits form for reporting instances where a member indicates that they did not receive a service from a provider. The instructions and template can be found at the PI SharePoint site.

Section 11.1: Good Cause Exception (GCE) Form

Notifies the MCOs of a potential fraud referral for a provider of which they may request a payment suspension exception. The instructions and template can be found at the PI SharePoint site.

Section 11.1: Permissions Form

To request permission to conduct a targeted BEOMB run. The instructions and template can be found at the PI SharePoint site.

Section 11.1: Provider Suspensions

1) Suspension, Termination, Exclusion excel lists are located in DHHS' Share Point site and are found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

2) Program Integrity Instructions for use of SharePoint for Reporting Provider Suspensions, Terminations and Exclusions can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

3) Provider Suspension, Exclusions, and Terminations Templates can be found on the Program Integrity SharePoint Site.

An example of an *MCO Payment Suspension Letter* can be found below. Additional mailing requirements of this letter include:

- Letter should be sent as certified mail
- Letter should be addressed as personal and confidential

Example: MCO Payment Suspension Letter

Dear <Provider>:

The purpose of this letter is to inform you that in conjunction with the letter issued to you on <date of SCDHHS letter> by the South Carolina Department of Health and Human Services (SCDHHS), <Plan Name> will be withholding payment for services issued under <Group/Individual ID> for <Group/Individual Name>. The action taken by SCDHHS is in accordance with 42 CFR § 455.23 regarding suspension of payments in cases of a credible allegation of fraud.

SCDHHS requires that in response to the suspension of payments in cases of credible allegations of fraud that <Plan Name> also suspend payments. The withholding of payments will continue until <Plan Name> is notified by SCDHHS that SCDHHS or the Medicaid Fraud Control Unit of the State Attorney General's Office has determined that there is insufficient evidence of fraud by the provider or that legal proceedings related to the alleged fraud are completed.

The State authority for this review and recovery of improper payments can be found at South Carolina Code of Regulations 126.400 et seq.; the federal authority may be found at 42 CFR § 433.300 et seq.; see also 42 CFR § 431.107; 42 CFR Part 455; and 42 CFR Part 456.

Please do not hesitate to call should you have any questions regarding this letter.

Sincerely,

<Plan Representative Name>

<Plan Name>

Enclosure: Healthy Connections Medicaid Payment Suspension Letter dated <xxxxx>
cc: Betsy Corley, SCDHHS PI

Section 11.1: MCO Provider Termination Monthly Report

MCO report required for monthly provider termination case reporting to program integrity can be found at the Program Integrity SharePoint site.

Section 11.1: Quarterly MCO Fraud and Abuse Report

The Quarterly Fraud and Abuse Report and Instructions can be found at the Program Integrity SharePoint site.

Section 11.1: Program Integrity Annual Strategic Plan

The PI Annual Strategic Plan Matrix can be found at the Program Integrity SharePoint site.

Section 11.2: Program Integrity Written Compliance Plan

The PI Compliance Plan Matrix for MCOs to complete can be found at the Program Integrity SharePoint site. This report should be uploaded directly to PI via the PI SharePoint site annually and whenever changes are required to the report.

Section 11.10: Pharmacy Lock-In Letters / Notifications

The templates must be used for Pharmacy Lock-In Member Notification (Pharmacy LI Member Letter), Member Instructions (Pharmacy LI Member INSTRUCTIONS rev 2-15-17), Member Removal (Pharmacy LI Member Removal Letter), and Pharmacy Notification (Pharmacy LI Pharmacy Letter). The only MCO modifications allowed to the templates are highlighted in yellow. These sections must be modified.

Please note that the Pharmacy LI Member Letter should include language to address Section 1557 of the Patient Protection and Affordable Care Act Addendum. The Pharmacy Lock-In letters/notifications can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

SECTION 12- MARKETING REQUIREMENTS

Section 12.4: Member Material Attestation Form

The minimal attestation form is used when there is a minimal change to a member material or PR material that does not require content changes.

To utilize a minimal attestation form request, please complete and upload the form to the Material Review SharePoint Site using the material minimal attestation naming convention in Section 12.4 of the P&P.

Field definitions are listed below. MCO's are encouraged to add additional information as necessary in the "other" field to support their request.

An example of the Minimal Change Attestation Form may be found below. The form template can be found on the DHHS website at https://www.scdhhs.gov/resources/health-managed-care-plans/managed-care-organizations-mco/policy-and-procedure-pp

Example: Minimal Change Attestation Form

MINIMAL CHANGE ATTESTATION

Plan Name: Choose an item.

Date: Click or tap to enter a date.

Previous Naming Convention: Click or tap here to enter text.

Current Naming Convention: Click or tap here to enter text.

Current Naming Convention Example: MC-07212023-PR-1.1-WM-U-A (update the "version" in the naming convention and add "A" for attestation)

****** The new naming convention must be added to the updated material.

[**Choose an item.**] attest that the content of this document is not changing. The following minimal changes to document [naming convention] are as follows:

☐**Fax number:** Click or tap here to enter text.

☐**Email address:** Click or tap here to enter text.

☐**Mailing address:** Click or tap here to enter text.

☐**County name:** Click or tap here to enter text.

☐**Phone number**: Click or tap here to enter text.

☐**Other, please explain**: Click or tap here to enter text.

Signature: Click or tap here to enter text. **Date:** Click or tap to enter a date.

****By entering your name, you attest that the information above is true and correct. ****

Section 12.3: Marketing Activities Submission Log

This log is used for MCOs to document upcoming marketing activities they are participating in/sponsoring. The template has been added to each MCO's SharePoint Managed Care site under the "Required Submissions" library. Monthly Tabs are located at the bottom. Log your event under the tabs based on the month in which you are submitting the event information.

For example: A future event for November 1, 2017 submitted in April, would be logged under the April 2017 tab.

Events on the spreadsheet should be listed in the order of submission, but each column heading has a sorting option available.

Example: Marketing Activities Submission Log

Jan **PLAN NAME:**

Submission Date	County	Event Date(s)	Name of Site and Name of Event	Is this a Sponsorship? Y/N	Address of Event	Event Hours	Event Contact Person Name, Title, & Phone #	Date of Participation Approval (by Event Sponsor)	Details of the Event	Social Media Use (Site Specific Tools)	Event Changes (cancel/ changed)

SECTION 13- REPORTING REQUIREMENTS

Section 13.1: Claims Payment Accuracy

This report is to be submitted to the MCO's monthly SharePoint library. The report details claims outcomes for the MCO's on a monthly basis and the template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 13.1: PRTF

This report is to be submitted to the MCO's monthly SharePoint library. The report details members currently in or discharged from a PRTF facility and the template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 13.1: GME Report Template

Report is utilized for reporting payments to teaching hospitals for DHHS calculation of the Graduate Medical Education reimbursement.

The Report Template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

SECTION 14- ENCOUNTER DATA, REPORTING AND SUBMISSION REQUIREMENTS

Section 14.5: Encounter Submission Summary

Report summarizing monthly claims paid, accepted encounters, rejected encounters, and completeness percentage.

File naming convention will be as follows:

> Report Name > Calendar Year > Data Period Month > Reporting Month
>
> *Example: "Encounter Submission Summary_2016DP02R03"*

For instance, a February 2016 Data Period would be Reported with the other March data due to be submitted April 15th.

Section 14.5 Encounter Edits Legacy and 277CA Encounter Edits

Mapping details can be found in the 'Additional Resources' section at: https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Additional details about Encounter Edits may also be found within the Encounters Companion Guides found on the DHHS website at https://www.scdhhs.gov/resources/health-managed-care-plans/managed-care-organizations-mco/policy-and-procedure-pp

Section 14.10: Encounter Quality Initiative (EQI) Report Template

MCOs are required to submit quarterly and annual Encounter Quality Initiative (EQI) reports to SCDHHS. The reporting schedule can be found in the MCO Process and Procedure Manual. SCDHHS will provide instructions and templates for this report in December of each year prior to their submission due dates.

SECTION 15- QUALITY MANAGEMENT AND PERFORMANCE

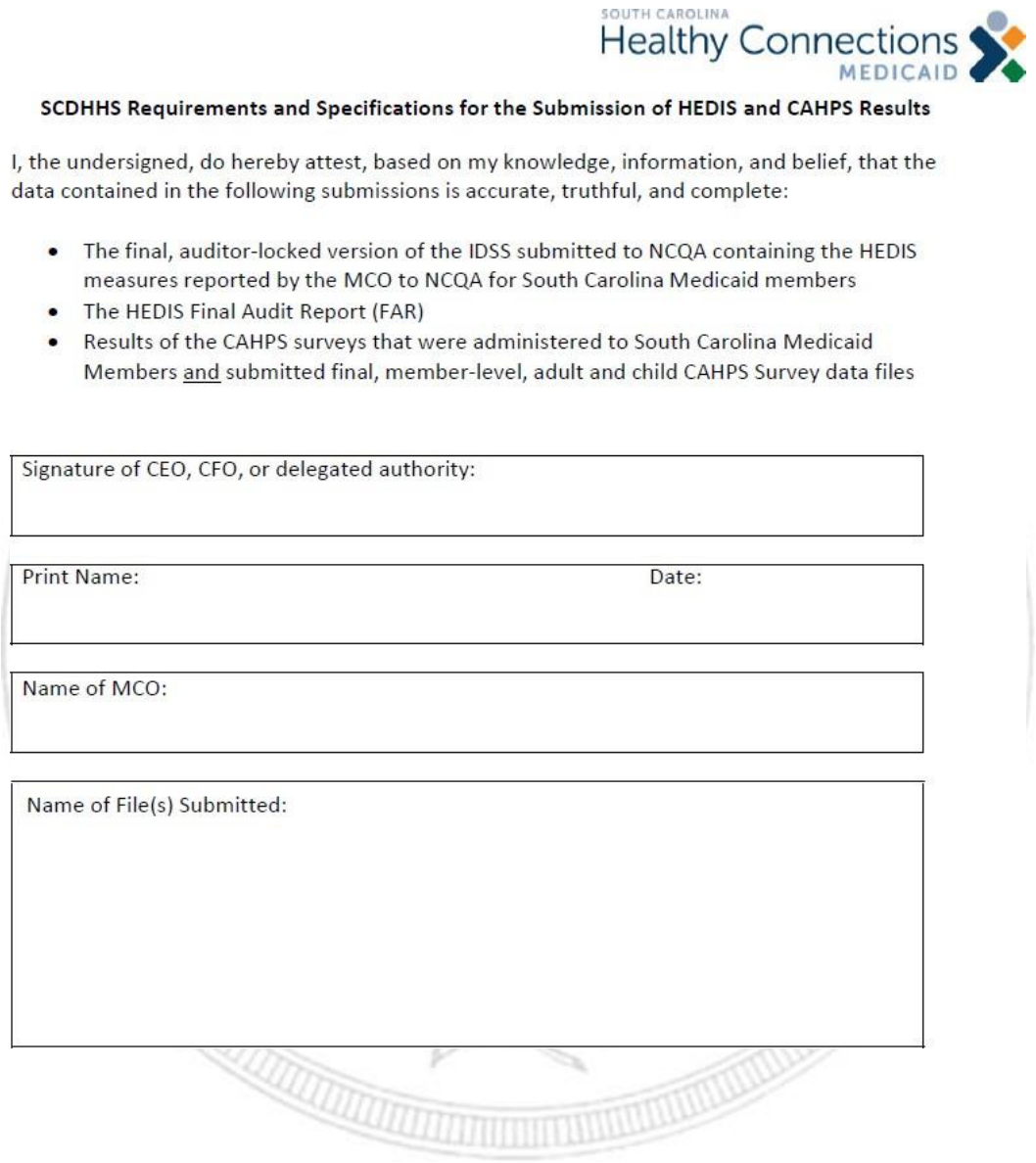
Section 15.1: Population Assessment Report

The MCO must submit annually to SCDHHS a population assessment report written as consistent with population assessment criteria set forth in NCQA's standards and guidelines for health plan accreditation. The population assessment should be sent as submitted to the MCO's quality committee. The assessment may be due at a date set by the MCO's quality committee, but no more than 14 months shall elapse between annual submissions of reports. The first population assessment shall be submitted no later than December 31, 2018. SCDHHS may request submission to SCDHHS other documentation that is also required for NCQA's health plan accreditation and will communicate with the MCO reasonable timeframes to correspond with creation of documentation, if needed.

Section 15.4: HEDIS and CAHPS Reports

These reports are NCQA defined reports and should follow the reporting requirements NCQA utilizes. Please upload these reports to the MCO's annual library in SharePoint. An example of the attestation form for these reports must accompany them and is reflected below.

Example: HEDIS and CAHPS Attestation



SOUTH CAROLINA Healthy Connections MEDICAID

SCDHHS Requirements and Specifications for the Submission of HEDIS and CAHPS Results

I, the undersigned, do hereby attest, based on my knowledge, information, and belief, that the data contained in the following submissions is accurate, truthful, and complete:

- The final, auditor-locked version of the IDSS submitted to NCQA containing the HEDIS measures reported by the MCO to NCQA for South Carolina Medicaid members
- The HEDIS Final Audit Report (FAR)
- Results of the CAHPS surveys that were administered to South Carolina Medicaid Members and submitted final, member-level, adult and child CAHPS Survey data files

Signature of CEO, CFO, or delegated authority:	
Print Name:	Date:
Name of MCO:	
Name of File(s) Submitted:	

Section 15.5: Alternative Payment Model

This report should be utilized by the MCO's to reflect alternative payment model contracts. The annual report should be submitted in the plans annual report folder on SharePoint with the following naming convention:

[PlanName]_APM CONTRACTING_RY [Two-Digit Reporting Year].xls.

The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

SECTION 16- DEPARTMENT RESPONSIBILITIES

Section 16.3: QA Grid

On occasion the MCO's may need to ask questions of SCDHHS. SCDHHS has developed a form to allow plans the ability to ask questions of SCDHHS.

The QA grid template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

APPENDIX E- BABYNET

Appendix E (of MCO Contract): BabyNet Members

The MCO will receive this report on the first Monday of the month and includes a list of BabyNet members.

An example of how the report will appear can be found below (*Example 1*). The data definitions for the BabyNet Members Report are as follows:

DATA POINT	DEFINITION
PLAN_ID	The Medicaid legacy ID (six characters) of the managed care organization with the BabyNet member
PLAN_NAME	The name of the managed care organization with the BabyNet member
MID	The Medicaid ID of the member
DOB	The Date of Birth of the member
PCAT	The eligibility category of the member
BNET_START	The BabyNet eligibility start date
BNET_END	The BabyNet eligibility end date
MCHM_ELIG	Managed care eligibility start date
MCHM_INELIG	Managed care eligibility end date
THERAPY_AUTH_FIRST_DOS	The first date of service for BabyNet eligibility. This date is derived from the Individualized Family Service Plan (IFSP)
THERAPY_AUTH_LAST_DOS	The last date of service for BabyNet eligiblity. This date is derived from date of birth and Individualized Family Service Plan information

Appendix E (of MCO Contract): BabyNet Providers

The MCO will receive this report on the first Monday of the month and includes a list of BabyNet billing and rendering providers.

An example of how the report will appear (to include billing and rendering providers) can be found below (*Example 2*). The data definitions for the BabyNet Providers Report (for both billing and rendering providers) are as follows:

DATA POINT **(BILLING PROVIDERS)**	**DEFINITION**
AGENCY ID	BabyNet defined Agency ID from Bridges care coordination system
AGENCY NAME	The name of the Provider organization/agency contracted with the BabyNet program
MMIS ID	The six digit Medicaid legacy provider ID of the agency/organization
MMIS MATCH TYPE	The search made between MMIS and Bridges to obtain the NPI and matching Medicaid legacy ID of the agency/organization
NPI	The ten digit national provider number of the contracted BabyNet agency/organization
TAXONOMY	The taxonomy code of the BabyNet agency/organization
TAX ID	The tax identification number of the organization
TAX ID TYPE	The type of tax identification number for the organization
CONTRACT START DATE	The start date of the contract between organization and BabyNet
CONTRACT END DATE	The end date of the contract between organization and BabyNet
CONTACT PERSON	Professional contact at the agency/organization
PHONE	Phone number of the BabyNet agency/organization
FAX	Fax number of the BabyNet agency/organization
EMAIL	Professional email contact at the BabyNet agency/organization
BILLING CONTACT PERSON	Professional billing contact at the BabyNet agency/organization
BILLING PHONE	Phone number of the billing office at the BabyNet agency/organization
BILLING EMAIL	Professional billing email address at the BabyNet agency/organization

DATA POINT (RENDERING PROVIDER)	DEFINITION
AGENCY ID	BabyNet defined Agency ID from Bridges care coordination system
AGENCY NAME	The name of the Provider organization/agency contracted with the BabyNet program
AGENCY MMIS ID	The six digit Medicaid legacy provider ID of the agency/organization
AGENCY MMIS MATCH TYPE	The search made between MMIS and Bridges to obtain the NPI and matching Medicaid legacy ID of the agency/organization
USER ID	Concatenated individual rendering provider name
LAST NAME	The last name of the individual rendering provider
FIRST NAME	The first name of the individual rendering provider
MMIS ID	The individual rendering six digit Medicaid legacy provider ID
MMIS MATCH TYPE	The search made between MMIS and Bridges to obtain the NPI and matching Medicaid legacy ID of the individual rendering provider
NPI	The National Provider Identification (NPI) number of the individual rendering provider
TAXONOMY	The taxonomy code of the individual rendering provider
DISCIPLINES	The types of services offered by the individual rendering provider
OTHER	Any miscellaneous services offered by the individual rendering provider not described in DISCIPLINES
PHONE	Phone number of the agency/organization
CELL PHONE	Cell Phone number of the individual rendering provider
EMAIL	Email of the individual rendering provider
ADD DATE	The date the individual was added to the Bridges care coordination system.

Example 1- BabyNet Members Report

PLAN_ID	PLAN_NAME	MID	DOB	PCAT	BNET_ START	BNET_ END	MCHM_ELIG	MCHM_INELIG	THERAPY_AUTH_ FIRST_DOS	THERAPY_AUTH_ LAST_DOS

Example 2

BabyNet Billing Provider

AGENCY ID	AGENCY NAME	MMIS ID	MMIS MATCH TYPE	NPI	TAXON- OMY	TAX ID	TAX ID TYPE	CONTR- ACT START DATE	CONTR -ACT END DATE	CONTACT PERSON	PHONE	FAX	EMAIL	BILLING CONTACT PERSON	BILL- ING PHONE	BILL- ING EMAIL

BabyNet Rendering Provider

AGENCY ID	AGENCY NAME	AGENCY MMIS ID	AGENCY MMIS MATCH TYPE	USER ID	LAST NAME	FIRST NAME	MMIS ID	MMIS MATCH TYPE	NPI	TAXON- OMY	DISCI- PLINES	OTHER	PHONE	CELL PHONE	EMAIL	ADD DATE

APPENDIX A

REGULATION 69-70 – ANNUAL AUDITED FINANCIAL REPORTING REGULATION

Section 1. Authority

This regulation is promulgated by the Director of Insurance (Director) of the South Carolina Department of Insurance (Department) pursuant to Section 38-3-110 of the South Carolina Code of Laws.

Section 2. Purpose and Scope

The purpose of this regulation is to improve the Department's surveillance of the financial condition of insurers, as defined in Section 3, by requiring (1) an annual audit of financial statements reporting the financial position and the results of operations of insurers by independent certified public accountants, (2) Communication of Internal Control Related Matters Noted in an Audit, and (3) Management's Report of Internal Control over Financial Reporting.

Every insurer shall be subject to this regulation. Insurers having direct premiums written in this state of less than $1,000,000 in any calendar year and less than 1,000 policyholders or certificate holders of direct written policies nationwide at the end of the calendar year shall be exempt from this regulation for the year (unless the Director makes a specific finding that compliance is necessary for the Director to carry out statutory responsibilities) except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of $1,000,000 or more will not be so exempt.

Foreign or alien insurers filing the Audited Financial Report in another state, pursuant to that state's requirement for filing of Audited Financial Reports, which has been found by the Director to be substantially similar to the requirements herein, are exempt from Sections 4 through 13 of this regulation if:

A copy of the Audited Financial Report, Communication of Internal Control Related Matters Noted in an Audit, and the Accountant's Letter of Qualifications that are filed with the other state are filed with the Director in accordance with the filing dates specified in Sections 4, 11 and 12, respectively (Canadian insurers may submit accountants' reports as filed with the Office of the Superintendent of Financial Institutions, Canada).

A copy of any Notification of Adverse Financial Condition Report filed with the other state is filed with the Director within the time specified in Section 10.

Foreign or alien insurers required to file Management's Report of Internal Control over Financial Reporting in another state are exempt from filing the Report in this state provided the other state has substantially similar reporting requirements and the Report is filed with the commissioner of the other state within the time specified.

This regulation shall not prohibit, preclude or in any way limit the Director from ordering or conducting or performing examinations of insurers under the rules and regulations of the Department and the practices and procedures of the Department.

Section 3. Definitions

The terms and definitions contained herein are intended to provide definitional guidance as the terms are used within this regulation.

“Accountant” or “independent certified public accountant” means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants (AICPA) and in all states in which he or she is licensed to practice; for Canadian and British companies, it means a Canadian-chartered or British-chartered accountant.

“Affiliate” of a specific person or a person “affiliated” with a specific person means a person that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with the specific person.

“Audit Committee” means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, and audits of financial statements of the insurer or group of insurers. The Audit Committee of any entity that controls a group of insurers may be deemed to be the Audit Committee for one or more of these controlled insurers solely for the purposes of this regulation at the election of the controlling person. Refer to Section 14(A)(5) for exercising this election. If an Audit Committee is not designated by the insurer, the insurer’s entire board of directors shall constitute the Audit Committee.

“Audited Financial Report” means and includes those items specified in Section 5 of this regulation.

“Indemnification” means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing of other misrepresentations made by the insurer or its representatives.

“Independent board member” has the same meaning as described in Section 14(A)(3).

“Insurer” includes any captive insurer, special purpose financial captives insurer, health maintenance organization, title insurer, fraternal organization, burial association, other association, corporation, partnership, society, order, individual, or aggregation of individuals engaging or proposing or attempting to engage as principals in any kind of insurance or surety business, including the exchanging of reciprocal or interinsurance contracts between individuals, partnerships, and corporations.

“Group of insurers” means those licensed insurers included in the reporting requirements of Title 38, Chapter 21 - Insurance Holding Company Regulatory Act, or a set of insurers as identified by

management, for the purpose of assessing the effectiveness of internal control over financial reporting.

“Internal control over financial reporting” means a process effected by an insurer’s board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation and includes those policies and procedures that:

Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements, i.e., those items specified in Section 5(B)(2) through 5(B)(7) of this regulation.

“SEC” means the United States Securities and Exchange Commission.

“Section 404” means Section 404 of the Sarbanes-Oxley Act of 2002 (15 USC Section 7201 et seq.) and the SEC’s rules and regulations promulgated thereunder.

“Section 404 Report” means management’s report on “internal control over financial reporting” as defined by the SEC and the related attestation report of the independent certified public accountant as described in Section 3(A)(1).

“SOX Compliant Entity” means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002 (15 USC Section 7201 et seq.): (i) the pre-approval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934) (15 USC Section 78a et seq.)); (ii) the Audit Committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934 (15 USC Section 78a et seq.)); and (iii) the internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

Section 4. General Requirements Related to Filing and Extensions for Filing of Annual Audited Financial Reports and Audit Committee Appointment

All insurers shall have an annual audit by an independent certified public accountant and shall file an Audited Financial Report with the Director on or before June 1 for the year ended December 31 immediately preceding. The Director may require an insurer to file an Audited Financial Report earlier than June 1 with ninety days advance notice to the insurer.

Extensions of the June 1 filing date may be granted by the Director for thirty-day periods upon a showing by the insurer and its independent certified public accountant of the reasons for

requesting an extension and determination by the Director of good cause for an extension. The request for extension must be submitted in writing not less than ten days prior to the due date in sufficient detail to permit the Director to make an informed decision with respect to the requested extension.

If an extension is granted in accordance with the provisions in Section 4B, a similar extension of thirty days is granted to the filing of Management's Report of Internal Control over Financial Reporting.

Every insurer required to file an annual Audited Financial Report pursuant to this regulation shall designate a group of individuals as constituting its Audit Committee, as defined in Section 3. The Audit Committee of an entity that controls an insurer may be deemed to be the insurer's Audit Committee for purposes of this regulation at the election of the controlling person.

Section 5. Contents of Annual Audited Financial Report

The annual Audited Financial Report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flow, and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the insurer's state of domicile.

The annual Audited Financial Report shall include the following:

- Report of independent certified public accountant.
- Balance sheet reporting admitted assets, liabilities, capital and surplus.
- Statement of operations.
- Statement of cash flow.
- Statement of changes in capital and surplus.

Notes to financial statements:

These notes shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Section 38-13-80 of the South Carolina Code of Laws with a written description of the nature of these differences.

The financial statements included in the Audited Financial Report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the Director, and the financial statement shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an Audited Financial Report, the comparative data may be omitted.

Section 6. Designation of Independent Certified Public Accountant

Each insurer required by this regulation to file an annual Audited Financial Report, within sixty days after becoming subject to the requirement, shall register with the Director in writing the name and address of the independent certified public accountant or accounting firm retained to conduct the annual audit set forth in this regulation. Insurers not retaining an independent certified public accountant on the effective date of this regulation shall register the name and address of their retained independent certified public accountant not less than six months before the date when the first Audited Financial Report is to be filed.

The insurer shall obtain a letter from the accountant and file a copy with the Director stating that the accountant is aware of the provisions of the insurance code and the regulations of the insurance department of the state of domicile that relate to accounting and financial matters and affirming that the accountant will express an opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by that insurance department, specifying such exceptions as the accountant may believe appropriate.

If the accountant who was the insurer's accountant for the immediately preceding filed Audited Financial Report is dismissed or resigns, the insurer shall notify the Director within five business days of this event. The insurer shall also furnish the Director with a separate letter within ten business days of the above notification stating whether in the twenty-four months preceding the event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure, which, if not resolved to the satisfaction of the former accountant, would have caused the accountant to make reference to the subject matter of the disagreement in connection with the opinion. The disagreements required to be reported in response to this section include those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer also in writing shall request the former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for the disagreement; and the insurer shall furnish the responsive letter from the former accountant to the Director together with its own.

Section 7. Qualifications of Independent Certified Public Accountant

The Director shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

1. Is not in good standing with the AICPA and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or
2. Has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

Except as otherwise provided in this regulation, the Director shall recognize an independent certified public accountant as qualified as long as the accountant conforms to the standards of the profession, as contained in the AICPA Code of Professional Conduct and the regulations of the South Carolina Board of Accountancy, or similar code.

A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Chapter 27 of Title 38 of the South Carolina Code of Laws, the mediation or arbitration provisions shall operate at the option of the statutory successor.

The lead or coordinating audit partner having primary responsibility for the audit may not act in that capacity for more than five consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same insurer or its insurance subsidiaries or affiliates for a period of five consecutive years. An insurer may make application to the Director for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least thirty days before the end of the calendar year. The Director may consider the following factors in determining if the relief should be granted:

1. Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;
2. Premium volume of the insurer; or
3. Number of jurisdictions in which the insurer transacts business.

The insurer shall file, with its annual statement filing, the approval for relief from Subsection D with the states that it is licensed in or doing business in and with the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

The Director shall not recognize as a qualified independent certified public accountant or accept any annual Audited Financial Report prepared in whole or in part by any person who:

1. Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 U.S.C. Section 1961 et seq., or any dishonest conduct or practices under federal or state law;
2. Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this regulation; or
3. Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of this regulation.

The Director, pursuant to statute, may hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his or her opinion on the financial statements in the annual Audited Financial Report made pursuant to this regulation and require

the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this regulation.

The Director shall not recognize as a qualified independent certified public accountant or accept an annual Audited Financial Report prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following non-audit services:

1. Bookkeeping or other services related to the accounting records or financial statements of the insurer;
2. Financial information systems design and implementation;
3. Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;
4. Actuarially-oriented advisory services involving the determination of amounts recorded in the financial statements.

The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification ("opinion") on an insurer's reserves if the following conditions have been met:

1. Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;
2. The insurer has competent personnel (or engages a third-party actuary) to estimate the reserves for which management takes responsibility; and
3. The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;
4. Internal audit outsourcing services;
5. Management functions or human resources;
6. Broker or dealer, investment adviser, or investment banking services;
7. Legal services or expert services unrelated to the audit; or
8. Any other services that the Director determines, by regulation, are impermissible.

In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit their own work, and cannot serve in an advocacy role for the insurer.

Insurers having direct written and assumed premiums of less than $100,000,000 in any calendar year may request an exemption from Subsection H. The insurer shall file with the Director a written statement discussing the reasons why the insurer should be exempt from these provisions. An exemption may be granted if the Director finds, upon review of this statement, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer.

A qualified independent certified public accountant who performs the audit may engage in other non- audit services, including tax services, that are not described in Subsection H or that do not conflict with Subsection I, only if the activity is approved in advance by the Audit Committee, in accordance with Subsection L.

All auditing services and non-audit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be pre-approved by the Audit Committee. The pre-approval requirement is waived with respect to non-audit services if the insurer is a SOX compliant entity or a direct or indirect wholly-owned subsidiary of a SOX compliant entity or:

1. The aggregate amount of all such non-audit services provided to the insurer constitutes not more than five percent of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the non-audit services are provided;
2. The services were not recognized by the insurer at the time of the engagement to be non-audit services; and
3. The services are promptly brought to the attention of the Audit Committee and approved prior to the completion of the audit by the Audit Committee or by one or more members of the Audit Committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the Audit Committee.

The Audit Committee may delegate to one or more designated members of the Audit Committee the authority to grant the pre-approvals required by Subsection L. The decisions of any member to whom this authority is delegated shall be presented to the full Audit Committee at each of its scheduled meetings.

The Director shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may make application to the Director for relief from the above requirement on the basis of unusual circumstances.

The insurer shall file, with its Annual Statement filing, the Director’s letter granting relief from Subsection N with the states in which it is licensed or doing business and with the NAIC. If the non- domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 8. Consolidated or Combined Audits

An insurer may make written application to the Director for approval to include in its Audited Financial Report audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies that utilizes a

pooling or one hundred percent reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining worksheet shall be filed with the report, as follows:

1. Amounts shown on the consolidated or combined Audited Financial Report shall be shown on the worksheet;
2. Amounts for each insurer subject to this section shall be stated separately;
3. Noninsurance operations may be shown on the worksheet on a combined or individual basis;
4. Explanations of consolidating and eliminating entries shall be included; and
5. A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the worksheet and comparable amounts shown on the annual Statements of the insurers.

Section 9. Scope of Audit and Report of Independent Certified Public Accountant

Financial statements furnished pursuant to Section 5 shall be examined by the independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. In accordance with Auditing (AU) Section 319 of the AICPA Professional Standards, Consideration of Internal Control in a Financial Statement Audit, the independent certified public accountant shall obtain an understanding of internal control sufficient to plan the audit. To the extent required by AU Section 319, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to Section 16, the independent certified public accountant should consider (as that term is defined in Statements on Auditing Standards (SAS) No. 102 of the AICPA Professional Standards, Defining Professional Requirements in Statements on Auditing Standards or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

Section 10. Notification of Adverse Financial Condition

A. The insurer required to furnish the annual Audited Financial Report shall require the independent certified public accountant to report, in writing, within five business days to the board of directors or its Audit Committee any determination by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the Director as of the balance sheet date currently under audit or that the insurer does not meet the minimum capital and surplus requirement of the South Carolina Code of Laws as of that date. An insurer that has received a report pursuant to this paragraph shall forward a copy of the report to the Director within five business days of receipt of the report and shall provide the independent certified public accountant making

the report with evidence of the report being furnished to the Director. If the independent certified public accountant fails to receive the evidence within the required five business day period, the independent certified public accountant shall furnish to the Director a copy of its report within the next five business days.

B. No independent certified public accountant shall be liable in any manner to any person for any statement made in connection with the above paragraph if the statement is made in good faith in compliance with Subsection A.
C. If the accountant, subsequent to the date of the Audited Financial Report filed pursuant to this regulation, becomes aware of facts that might have affected his or her report, the Director notes the obligation of the accountant to take such action as prescribed in AU 561 of the AICPA Professional Standards, Subsequent Discovery of Facts Existing at the Date of the Auditor's Report.

Section 11. Communication of Internal Control Related Matters Noted in an Audit

A. In addition to the annual Audited Financial Report, each insurer shall furnish the Director with a written communication as to any unremediated material weaknesses in its Internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty days after the filing of the annual Audited Financial Report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined in SAS No. 112 of the AICPA Professional Standards, Communicating Internal Control Related Matters Identified in an Audit, or its replacement) as of December 31 immediately preceding (so as to coincide with the Audited Financial Report discussed in Section 4(A)) in the insurer's Internal control over financial reporting identified by the accountant during the course of the audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.
B. The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses, if the actions are not described in the accountant's communication.
C. The insurer is expected to maintain information about significant deficiencies communicated by the independent certified public accountant. The information should be made available to the examiner conducting a financial examination for review and kept in a manner as to remain confidential.

Section 12. Accountant's Letter of Qualifications

The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual Audited Financial Report, a letter stating:

1. That the accountant is independent with respect to the insurer and conforms to the standards of their profession as contained in the AICPA's Code of Professional Conduct and pronouncements of its Financial Accounting Standards Board and the South Carolina Board of Accountancy, or similar code;

2. The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this regulation shall be construed as prohibiting the accountant from utilizing such staff as deemed appropriate where use is consistent with the standards prescribed by generally accepted auditing standards;
3. That the accountant understands the annual Audited Financial Report and that its opinion thereon will be filed in compliance with this regulation and that the Director will be relying on this information in the monitoring and regulation of the financial position of insurers;
4. That the accountant consents to the requirements of Section 13 of this regulation and that the accountant consents and agrees to make available for review by the Director, or the Director's designee or appointed agent, the workpapers, as defined in Section 13;
5. A representation that the accountant is properly licensed by an appropriate state licensing authority and is a member in good standing in the AICPA; and
6. A representation that the accountant is in compliance with the requirements of Section 7 of this regulation.

Section 13. Definition, Availability and Maintenance of Independent Certified Public Accountants Workpapers

A. Workpapers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained, and the conclusions reached pertinent to the accountant's audit of the financial statements of an insurer. Workpapers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of insurer documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his or her audit of the financial statements of an insurer and which support the accountant's opinion.

B. Every insurer required to file an Audited Financial Report pursuant to this regulation, shall require the accountant to make available for review by Department examiners, all workpapers prepared in the conduct of the accountant's audit and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Department or at any other reasonable place designated by the Director. The insurer shall require that the accountant retain the audit workpapers and communications until the Department has filed a report on examination covering the period of the audit but no longer than seven years from the date of the audit report.

C. In the conduct of the aforementioned periodic review by the Department examiners, it shall be agreed that photocopies of pertinent audit workpapers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all working papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination workpapers generated by the department.

Section 14. Requirements for Audit Committees

This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly-owned subsidiary of a SOX Compliant Entity.

The Audit Committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the Audited Financial Report or related work pursuant to this regulation. Each accountant shall report directly to the Audit Committee.

Each member of the Audit Committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to Subsection (A)(5) of this Section and Section 3(A)(C).

In order to be considered independent for purposes of this section, a member of the Audit Committee may not, other than in his or her capacity as a member of the Audit Committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise non-independent members, that law shall prevail and such members may participate in the Audit Committee and be designated as independent for Audit Committee purposes, unless they are an officer or employee of the insurer or one of its affiliates.

If a member of the Audit Committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the Director, may remain an Audit Committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one year from the occurrence of the event that caused the member to be no longer independent.

To exercise the election of the controlling person to designate the Audit Committee for purposes of this regulation, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the Director by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

The Audit Committee shall require the accountant that performs for an insurer any audit required by this regulation to timely report to the Audit Committee in accordance with the requirements of SAS No. 114 of the AICPA Professional Standards, The Auditor's Communication with those Charged with Governance, or its replacement, including:

1. All significant accounting policies and material permitted practices;
2. All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer,

ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

3. Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

If an insurer is a member of an insurance holding company system, the reports required by Subsection (A)(6) may be provided to the Audit Committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the Audit Committee.

The proportion of independent Audit Committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums		
$0 - $300,000,000	$300,000,000- $500,000,000	Over $500,000,000
No minimum requirements. See also Note A and B.	Majority (50% or more) of members shall be independent. See also Note A and B.	Supermajority of members (75% or more) shall be independent. See also Note A.

Note A: The Director has authority afforded by state law to require the insurer's board to enact improvements to the independence of the Audit Committee membership if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than $500,000,000 in prior year direct written and assumed premiums are encouraged to structure their Audit Committees with at least a supermajority of independent Audit Committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from non-affiliates for the reporting entities.

An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than $500,000,000 may make application to the Director for a waiver from the Section 14 requirements based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from Section 14 with the states that it is licensed in or doing business in and the NAIC. If the non-domestic state accepts electronic filing with the NAIC, the insurer shall file the approval in an electronic format acceptable to the NAIC.

Section 15. Conduct of Insurer in Connection with the Preparation of Required Reports and Documents

No director or officer of an insurer shall, directly or indirectly:

1. Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this regulation; or
2. Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this regulation.

No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this regulation if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

For purposes of Subsection B, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

1. To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the Director, generally accepted auditing standards, or other professional or regulatory standards);
2. Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;
3. Not to withdraw an issued report; or
4. Not to communicate matters to an insurer's Audit Committee.

Section 16. Management's Report of Internal Control over Financial Reporting

Each insurer required to file an Audited Financial Report pursuant to this regulation that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of $500,000,000 or more shall prepare a report of the insurer's or group of insurers' Internal Control Over Financial Reporting, as these terms are defined in Section 3. The report shall be filed with the Director along with the Communicating Internal Control Related Matters Identified in an Audit described under *Section 11. Management's Report of Internal Control Over Financial Reporting* shall be as of December 31 immediately preceding.

Notwithstanding the premium threshold in Subsection A, the Director may require an insurer to file Management's Report of Internal Control Over Financial Reporting if the insurer is in any RBC level event or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in S.C. Code Ann. Sections 35-5-120, 38-9-150, 38-9-360, and 38-9-440.

An insurer or a group of insurers that is:

1. directly subject to Section 404;
2. part of a holding company system whose parent is directly subject to Section 404;
3. not directly subject to Section 404 but is a SOX compliant entity; or
4. a member of a holding company system whose parent is not directly subject to Section 404 but is a SOX compliant entity;

may file its or its parent's Section 404 Report and an addendum in satisfaction of this Section's requirement provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 5(B)(2) through 5(B)(7) of this regulation) were included in the scope of the Section 404 Report.

The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements (those items included in Section 5(B)(2) through 5(B)(7) of this regulation) excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file (i) a Section 16 report, or (ii) the Section 404 Report and a Section 16 report for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 Report.

Management's Report of Internal Control Over Financial Reporting shall include:

1. A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;
2. A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;
3. A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its internal control over financial reporting;
4. A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;
5. Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management shall not conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there are one or more unremediated material weaknesses in its internal control over financial reporting;
6. A statement regarding the inherent limitations of internal control systems; and

7. Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

Management shall document and make available upon financial condition examination the basis upon which its assertions, required in Subsection D, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost effective manner and, as such, may include assembly of or reference to existing documentation.

Management's Report on Internal Control over Financial Reporting, required by Subsection A , and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the Director.

Section 17. Exemptions

Upon written application of an insurer, the Director may grant an exemption from compliance with any provision or requirement of this regulation if the Director finds, upon review of the application, that compliance with this regulation would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten days from a denial of an insurer's written request for an exemption from this regulation, the insurer may request in writing a hearing, pursuant to statute, on its application for an exemption. The hearing shall be held in accordance with the statutes of the Department pertaining to administrative hearing procedures.

Section 18. Canadian and British Companies

For Canadian and British insurers, the annual Audited Financial Report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

For such insurers, the letter required in Section 6B shall state that the accountant is aware of the requirements relating to the annual Audited Financial Report filed with the Director pursuant to Section 4 and shall affirm that the opinion expressed is in conformity with those requirements.

Section 19. Effective dates

Unless otherwise noted, the requirements of this regulation shall become effective for the reporting period ending December 31, 2010 and each year thereafter. An insurer or group of insurers not required to file a report because its total written premium is below the threshold that subsequently becomes subject to the reporting requirements shall have two years following the year the threshold is exceeded (but not earlier than December 31, 2010) to file the report. Likewise, an insurer acquired in a business combination shall have two calendar years following the date of acquisition or combination to comply with the reporting requirements.

The requirements of Section 7D shall become effective for audits of the year beginning January 1, 2010 and thereafter.

The requirements of Section 14 shall become effective on January 1, 2010. An insurer or group of insurers that is not required to have independent Audit Committee members or only a majority of independent Audit Committee members (as opposed to a supermajority) because the total direct written and assumed premium is below the threshold and subsequently becomes subject to one of the independence requirements due to changes in premium shall have one year following the year the threshold is exceeded (but not earlier than January 1, 2010) to comply with the independence requirements. Likewise, an insurer that becomes subject to one of the independence requirements as a result of a business combination shall have one calendar year following the date of acquisition or combination to comply with the independence requirements.

Section 20. Severability Provision

If any section or portion of a section of this regulation or its applicability to any person or circumstance is held invalid by a court, the remainder of the regulation or the applicability of the provision to other persons or circumstances shall not be affected.

HEALTH MAINTENANCE ORGANIZATIONS COMPANY NAME:_____

NAIC Company Code:_____ Contact:_____ Telephone:_____

REQUIRED FILINGS IN THE STATE OF:_____ Filings Made During the Year 2017

(1) CHECK-LIST	(2) LINE #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES*			(5) DUE DATE	(6) FORM SOURCE **	(7) APPLICABLE NOTES
			Domestic		Foreign			
			State	NAIC	State			
		I. NAIC FINANCIAL STATEMENTS						
	1	Annual Statement (8 ½"X14")	1	EO	xxx	3/1	NAIC	
	1.1	Printed Investment Schedule detail (Pages E01-E27)	1	EO	xxx	3/1	NAIC	
	2	Quarterly Financial Statement (8 ½" x 14")	1	EO	xxx	5/15, 8/15, 11/15	NAIC	
		II. NAIC SUPPLEMENTS						

	10	Accident & Health Policy Experience Exhibit	1	EO	xxx	4/1	NAIC	
	11	Actuarial Opinion	1	EO	xxx	3/1	Company	
	12	Health Care Exhibit (Parts 1, 2 and 3) Supplement	1	EO	xxx	4/1	NAIC	
	13	Health Care Exhibit's Allocation Report Supplement	1	EO	xxx	4/1	NAIC	
	14	Investment Risk Interrogatories	1	EO	xxx	4/1	NAIC	
	15	Life Supplemental Data due March 1	1	EO	xxx	3/1	NAIC	
	16	Life Supp Statement non-guaranteed elements –Exh 5, Int. #3	1	EO	xxx	3/1	Company	
	17	Life Supp Statement on par/non-par policies – Exh 5 Int. 1&2	1	EO	xxx	3/1	Company	
	18	Life Supplemental Data due April 1	1	EO	xxx	4/1	NAIC	
	19	Long-term Care Experience Reporting Forms	1	EO	xxx	4/1	NAIC	
	20	Management Discussion & Analysis	1	EO	xxx	4/1	Company	
	21	Medicare Supplement Insurance Experience Exhibit	1	EO	xxx	3/1	NAIC	
	22	Medicare Part D Coverage Supplement	1	EO	xxx	3/1, 5/15, 8/15, 11/15	NAIC	
	23	Property/Casualty Supplement due March 1	1	EO	xxx	3/1	NAIC	
	24	Property/Casualty Supplement due April 1	1	EO	xxx	4/1	NAIC	
	25	Risk-Based Capital Report	1	EO	xxx	3/1	NAIC	
	26	Schedule SIS	1	N/A	N/A	3/1	NAIC	
	27	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	

		III. ELECTRONIC FILING REQUIREMENTS						
	50	Annual Statement Electronic Filing	xxx	1	xxx	3/1	NAIC	
	51	March .PDF Filing	xxx	1	xxx	3/1	NAIC	
	52	Risk-Based Capital Electronic Filing	xxx	1	N/A	3/1	NAIC	
	53	Risk-Based Capital .PDF Filing	xxx	1	N/A	3/1	NAIC	
	54	Supplemental Electronic Filing	xxx	1	xxx	4/1	NAIC	
	55	Supplemental .PDF Filing	xxx	1	xxx	4/1	NAIC	
	56	June .PDF Filing	xxx	1	xxx	6/1	NAIC	
	57	Quarterly Electronic Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
	58	Quarterly .PDF Filing	xxx	1	xxx	5/15, 8/15, 11/15	NAIC	
		IV. AUDIT/INTERNAL CONTROL RELATED REPORTS						
	71	Accountants Letter of Qualifications	1	EO	N/A	6/1	Company	T
	72	Audited Financial Reports	1	EO	xxx	6/1	Company	U
	73	Audited Financial Reports Exemption Affidavit	1	N/A	N/A	3/1	Company	V
	74	Communication of Internal Control Related Matters Noted in Audit	1	N/A	N/A	8/1	Company	W
	75	Independent CPA : Designation/Change/Qualifications	1	N/A	N/A	Within 5 business days	Company	X
	76	Management’s Report of Internal Control Over Financial	1	N/A	N/A	8/1	Company	Y

		Reporting						
	77	Notification of Adverse Financial Condition	1	N/A	N/A	Within 5 business days of	Company	Z
	78	Request for Exemption to File	1	N/A	N/A	3/1	Company	AA
	79	Request to File Consolidated Audited Annual Statements	1	N/A	N/A	12/1	Company	BB
	80	Relief from the five-year rotation requirement for lead audit partner	1	EO	1	3/1	Company	CC
	81	Relief from the one-year cooling off period for independent CPA	1	EO	1	3/1	Company	DD
	82	Relief from the Requirements for Audit Committees	1	EO	1	3/1	Company	EE
		V. STATE REQUIRED FILINGS						
	101	Certificate of Compliance of Advertising. See 25A S.C. Code Ann. Regulation 69-17, Section 17. (Insurers Writing A&H, Only)	1	0	1	3/1	Company	O
	102	Filings Checklist (with Column 1 completed)	1	0	0	3/1	State	
	103	Holding Company Registration Statement	1	0	0	3/1	State	
	104	Premium Tax Electronic Filing	1	0	1	3/1	State	P
	105	SC Health Ins. Pool Assessment Base Reporting Form	1	0	1	3/1	State	Q
	106	State Filing Fees Electronic Filing	1	0	1	3/1	State	R
	107	Comprehensive Annual Analysis	1	0	0	3/15	State	N

	108	Comprehensive Quarterly Analysis	1	0	0	6/1, 9/1, 12/1	State	N

*If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing).

**If Form Source is NAIC, the form should be obtained from the appropriate vendor.

***For those states that have adopted the NAIC updated Holding Company Model Act, a Form F filing is required annually by holding company groups. Consistent with the Form B filing requirements, the Form F is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm

****For those states that have adopted the NAIC updated Risk Management and Own Risk and Solvency Assessment Model Act, a summary report is required annually by insurers and insurance groups above a specified premium threshold. Consistent with the Form B filing requirements, the ORSA Summary Report is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL: http://www.naic.org/public_lead_state_report.htm

NOTES AND INSTRUCTIONS (A-K APPLY TO ALL FILINGS)

A	Required Filings Contact Person:	Chief Financial Analyst Michael Shull Financial Regulation & Solvency Division mshull@doi.sc.gov 803-737-6221	Premium Tax Form Questions: Tax Manager Sharon Waddell swaddell@doi.sc.gov 803-737-4910
B	Mailing Address:	Physical Address: South Carolina Department of Insurance 1201 Main Street, Suite 1000 Columbia, SC 29201	Mailing Address: South Carolina Department of Insurance Post Office Box 100105 Columbia, South Carolina 29202-3105
C	Mailing Address for Filing Fees:	N/A. Electronic filing now required. Go to https://online.doi.sc.gov/Eng/Members/Login.aspx, and enter UserId and Password to access Insurer Fee & Premium Tax Forms and Instructions.	
D	Mailing Address for Premium Tax Payments:	N/A. Electronic filing now required. Go to https://online.doi.sc.gov/Eng/Members/Login.aspx, and enter UserId and Password to access Insurer Fee & Premium Tax Forms and Instructions.	

E	Delivery Instructions:	All required filings must be physically received in the Department no later than the indicated due date. If the due date falls on a weekend or a holiday, the next business day will be considered the due date.
F	Late Filings:	Companies will be fined for a late filing on a case-by-case basis.
G	Original Signatures:	Original signatures are required on all required filings.
H	Signature/ Notarization/ Certification:	Required annual statements must be verified by at least two of its principal officers, at least one of whom prepared or supervised the preparation of the annual statement. See S.C. Code Ann. Section 38-13-80(A).
I	Amended Filings:	Amended items must be filed within 10 days of their amendment, along with an explanation of the amendments. The signature requirements for the original filing should be followed for any amendment.
J	Exceptions from normal filings:	Foreign companies should supply a written copy of any exemption or extension received by its state of domicile at least 10 days prior to the filing due date to receive an exemption or extension from the Department. Domestic companies should apply for an exemption or extension at least fifteen days prior to the filing due date.
K	Bar Codes (State or NAIC):	Required only for NAIC filings. Please follow the instructions in the NAIC Annual Statement Instructions.
L	Signed Jurat:	Not required from foreign insurers.
M	NONE Filings:	See NAIC Annual Statement Instructions.
N	CAA and CQA	Domestics, only. The filings must be submitted electronically in Microsoft Word format to the Chief Financial Analyst via mshull@doi.sc.gov. A hard copy filing is not required.
O	Special Filings:	Certificate of Compliance of Advertising (insurers writing A&H, only) pursuant to 25A S.C. Code Ann. Regulation 69-17, Section 17B. Each insurer required to file an Annual Statement which is now or which hereafter becomes subject to the provisions of these rules must file with the Department a Certificate of Compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of his knowledge, information and belief, the advertisements which were disseminated by the insurer during the preceding statement year complied or were made to comply in all respects with the provisions of these rules and the Insurance Laws of this State as implemented and interpreted by these rules.
P	Insurer Fee & Premium Tax Forms and Instructions:	Electronic filing now required. Go to https://online.doi.sc.gov/Eng/Members/Login.aspx and enter UserId and Password to access Insurer Fee & Premium Tax Forms and Instructions. Questions: Sharon Waddell, Tax Manager, swaddell@doi.sc.gov or 803-737-4910.

Q	SC Health Ins. Pool Assessment Base Reporting Form:	The SC Health Insurance Pool Assessment Base Reporting Form will not be faxed. See "Attachments to State Filing Checklists."
R	Filing Fees:	Electronic filing now required. Go to https://online.doi.sc.gov/Eng/Members/Login.aspx and enter UserId and Password to access Insurer Fee & Premium Tax Forms and Instructions. Questions: Sharon Waddell, Tax Manager, swaddell@doi.sc.gov or 803-737-4910.
S	Actuarial Opinion Summary:	In addition to Statements of Actuarial Opinion filed with annual financial statements on or before March 1 the Actuarial Opinion Summary (AOS) is required by March 15. The AOS will be maintained as confidential by the Department pursuant to S.C. Code Ann. Section 38-13-160 (2002). The AOS must be prepared as prescribed by the instructions including but not limited to: • the actuary's range of reasonable estimates and/or point estimates for loss and loss adjustment expense reserves • the difference between the insurer's carried reserves and the point estimate and/or range of reasonable estimates an explanation of any exceptional adverse development
T	Accountants Letter of Qualifications:	See Section 12 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
U	Audited Financial Reports:	See Section 4 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
V	Audited Financial Reports - Exemptions Affidavit:	See Section 17 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists." Insurer must file (i.e., it is not automatically exempt) either: Premium and Policyholders or Certificate holders Exemption Affidavit or Financial or Organizational Hardship Exemption Affidavit which can be accessed under "Attachments to State Filing Checklists."
W	Communication of Internal Control Related Matters Noted in Audit:	See Section 11 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
X	Independent CPA: Designation/Change/ Qualifications:	See Sections 6 and 7 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."

Y	Management's Report of Internal Control Over Financial Reporting:	See Section 16 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
Z	Notification of Adverse Financial Condition:	See Section 10 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
AA	Request for Exemption to File:	See V. above.
BB	Request to File Consolidated Audited Annual Statements:	See Section 8 of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists."
CC	Relief from the five-year rotation requirement for lead audit partner	South Carolina only requires this report if a company has requested relief from its domiciliary state and does not intend to file its request electronically with the NAIC. For further guidance see Sections 7D & 7E of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklist" located on the Company Information Page of the SC Department of Insurance website.
DD	Relief from the one-year cooling off period for independent CPA	South Carolina only requires this report if a company has requested relief from its domiciliary state and does not intend to file its request electronically with the NAIC. For further guidance see Sections 7N & 7O of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklist" located on the Company Information Page of the SC Department of Insurance website.
EE	Relief from the Requirements for Audit Committees	South Carolina only requires this report if a company has requested relief from its domiciliary state and does not intend to file its request electronically with the NAIC. See Section 14(A) of Regulation 69-70 – Annual Audited Financial Reporting Regulation which can be accessed under "Attachments to State Filing Checklists" located on the Company Information Page of the SC Department of Insurance.

General Instructions for Companies to Use Checklist

This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.

Electronic Filing is intended to include filing via the Internet or filing via diskette with the NAIC. Companies that file with the NAIC via the Internet are not required to submit diskettes to the NAIC. Companies are not required to file hard copy filings with the NAIC.

Column (1) (Checklist)

Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an “x” in this column when mailing information to the state.

Column (2) (Line #)

Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) (Required Filings)

Name of item or form to be filed.

Annual Statement Electronic Filing- includes the annual statement data and all supplements due March 1, per the Annual Statement Instructions. This includes all detail investment schedules and other supplements for which the Annual Statement Instructions exempt printed detail.

March .PDF Filing- the .pdf file for annual statement data, detail for investment schedules and supplements due March 1. The Risk-Based Capital Electronic Filing includes all risk-based capital data.

Risk-Based Capital .PDF Filing- the .pdf file for risk-based capital data.

Supplemental Electronic Filing- includes all supplements due April 1, per the Annual Statement Instructions. The Supplemental .PDF Filing is the .pdf file for all supplemental schedules and exhibits due April 1. The Quarterly Statement Electronic Filing includes the complete quarterly statement data.

Quarterly Statement .PDF Filing- is the .pdf file for quarterly statement data.

Combined Annual Statement Electronic Filing- includes the required pages of the combined annual statement and the combined Insurance Expense Exhibit. The Combined Annual Statement .PDF Filing is the .pdf file for the Combined annual statement data and the combined Insurance Expense Exhibit.

June .PDF Filing- the .pdf file for the Audited Financial Statements and Accountants Letter of Qualifications.

Column (4) (Number of Copies)

Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (EX) Task Force modified the 1999 Annual Statement Instructions to waive paper filings of certain NAIC supplements and certain investment schedule detail. if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX) Task Force. XXX appears in the “Number of Copies” “Foreign” column for the appropriate schedules and exhibits. Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and to rely upon the NAIC

database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.

Column (5) (Due Date)

Indicates the date on which the company must file the form.

Column (6) (Form Source)

This column contains one of three words: “NAIC,” “State,” or “Company,” If this column contains “NAIC,” the company must obtain the forms from the appropriate vendor. If this column contains “State,” the state will provide the forms with the filing instructions. If this column contains “Company,” the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC Annual Statement Instructions.

Column (7) (Applicable Notes)

This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

APPENDIX B

REPORTING SENT THROUGH FTP SITE

FILES EXCHANGED BETWEEN SCDHHS AND MCOs

Updated: 05/25/2017

Basic rules for exchanging Electronic Data Interchange (EDI) files between South Carolina Department of Health and Human Services (SCDHHS) and a Managed Care entity will adhere to the following guidelines. These guidelines will work in conjunction with other documentation contained within this document. Additional documentation may be provided during implementation.

I. Naming Conventions

a. These files are proprietary files.
b. Files follow these naming conventions:
    i. XXXXXX.YYYYYYYY
        1. where XXXXXX is the provider number assigned by DHHS (ex: HM0500)
        2. where YYYYYYYY is a descriptive extension of up to 8 characters (does not have to be 8, but at most, 8 characters). File may not always contain this node.
    ii. Each node name (between the '.') has a max of eight characters.
        1. *Example: HM0500.ENCOUN.TEST*

II. Actual Files Sent to SSCDHHS From MCO

a. XXXXXX.PROV (SENT VIA EDI)
    i. This file must precede 837 and/or NCPDP submission of the encounters. The same day an encounter file is sent, the sender may also submit this non par provider file along with the 837 or NCPDP file. This will be sent via the MCO's EDI box (this is sent to the same place and via the same mode of transportation as the MCO's 837 and/or NCPDP). SCDHHS prefers a complete, cumulative Non-Par provider file.
        1. No control file is needed when sent to the EDI box.
b. XXXXXX.TPL (SENT VIA C:D)
    i. This full/complete file of all TPL information for each recipient for that given month is required to be submitted to DHHS by the eighth (8)th of the month. This file must be submitted even if there is no input. In the case of no input, a blank file must be submitted to SCDHHS.
c. 837 (SENT VIA EDI)

i. Each submission must be coordinated with DHHS. The sender must email the DHHS Information Systems Contact explaining how many files are being sent and the total number of records uploaded to the EDI box. There is not a standard naming convention. The translator will prepend and append data to the input file name. Please ensure that the TP's file name is not too long and is kept under 30 characters. Examples of possible file naming conventions can include:
    1. SC837IN_CCCCMMDD_SEQ_X12.txt (Institutional file)
    2. SC837PR_CCCCMMDD_SEQ_X12.txt (Professional file)

ii. This file is requested no later than the twenty-fifth (25)th of the month. The MCO may submit a file daily but should not submit files on Saturdays or Sundays. There is a 5,000 record limit per file and a 15 file max per day (so 75,000 records per day max).

iii. This file can also contain voids. The MCO has up to 18 months from the date an encounter was accepted at SCDHHS to void it.

d. XXXXXX.FQHCRHC.SUMMARY (SENT VIA C:D)
    i. This is the monthly wrap payment summary file and will be due by the 25th of the month.

e. XXXXXX.CAP.PAYMENTS (SENT VIA C:D)
    i. This is the monthly capitated payment summary file and will be due by the 25th of the month. *For example, if the MCO has 30 doctors that it sends a capitated payment each month, then there must be a record for each of the 30 doctors in this file, regardless of how many members each of these doctors sees during the month.*
    ii. The figures in this file represent monthly NET totals. If the MCO runs into negative amounts, then use the capitated payment void file. SCDHHS cannot accept negative amounts.

f. XXXXXX.CAP.PAYMENTS.VOID (SENT VIA C:D)
    i. This is the monthly capitated void payment summary file and will be due by the 25th of the month. If the MCO does not have capitated payment voids, then do NOT send this file every month.

III. Files Uploaded

a. Files may be uploaded at any point during the day. Files uploaded will be processed during the night. Do not upload files Saturday and Sunday.
b. All proprietary files will be required to have a control file associated with it. Control file details are contained in the SCDHHS document named: 0016 Use of control files for EDI.doc. No control file is required for EDI files to be sent to the MCO's EDI box. Control files are required only for proprietary files sent via connect direct.

IV. Actual Files and File Names Sent to MCO From SCDHHS

a. ZZZZZZ.ZZZZ.ZZZZZ (VIA EDI)
    i. This is the return encounter file sent back to the MCO and is typically sent within one (1) business day after processing. This file will be sent via the MCO's EDI box in the form of a

277CA. If the MCO receives an initial 277, then submission passed compliance on all 837s. The MCO will then get back another 277 after encounters have processed. NCPCP submissions will only get back the 277 after encounters have processed. The second 277 will contain the edits.

b. XXXXXX.CLAIMS.HISTORY (VIA C:D)
    i. Historical Fee for Service (FFS) claims, not encounter data. This file contains the prior 24 months of FFS claims data for each member in the MCO's cutoff MLE file. History for those assigned to the plan between cutoff and the first (1)st of the month will be included in the following months FFS claims history extract. This file is also sent on or about the 5th of every month.
    ii. The claims history file created after cutoff will have about a 3 - 4 week lag in data because the claims history process uses the FFS archive files.
        1. *For example, in the February 2010 claims history files created on or around February 25th, the most current FFS claim DHHS had was January 26, 2010. This means the MCO would not be receiving any FFS claims from January 27, 2010 forward. When DHHS ran the claims history file on March 3, 2010, all FFS claims from February 22, 2010 were retrieved due to only 9 days of lag.*
    iii. The claims history file for the MHNs is called SURE.CLAIMS.
c. XXXXXX.ENCOUNT.CLAIMHST (VIA C:D)
    i. This is 24 months of encounter data for the MCO's recipients. This file is sent on or around the 5th of every month.
d. XXXXXX.ENCOUNT.VOIDHST (VIA C:D)
    i. This is a file of any void encounters for the MCO's recipients. This file is sent on or around the 5th of every month.
e. MCXXXXXX (VIA C:D)
    i. This is a complete provider file created at MGC cutoff.
f. RSXXXXXX (VIA C:D)
    i. This is the MLE file created at MGC cutoff. It is also created on the first (1)st of the month. The first file is still an MLE but has special significance. During the MGC cutoff run, some recipients will be auto closed. These recipients will be reviewed, and if necessary, reinstated. All those reinstated will be reported in this file.
    ii. *Example: During the cutoff run for August, some recipients are auto closed. This means that the MCO will not get paid for them. During DHHS review, they are reinstated. They will be*

included in the MLE produced on the first (1)st of September. When the MGC cutoff run is completed for September (approximately the third (3)rd week of the month), the MCO will receive two premium payments. One payment will be retro for the payment missed in August, and the second payment will be for the current month of September. The MCO will be able to identify the retro payment.

iii. If the member regains eligibility within 60 days of the disenrollment date, the member will be automatically re-enrolled with the Contractor.

iv. If eligibility is regained after 60 days of the disenrollment date, the member will need to contract SCDHHS to initiate re-enrollment.

v. Retro payment for newborns will be included in the MLE at MGC cutoff.

g. XXXXXX.EPSDT.HIC (VIA C:D)

i. A special EPSDT system was developed, by DHHS, when the Federal EPSDT system was shut down. There are two files created with visit codes. One set for office visits and one set for injections. These files are created after the last payment run of the month. There is only 1 file that is sent on the 3rd Monday of each month.

h. XXXXXX.REVIEW.FILE (VIA C:D) & XXXXXX.REVIEWC.FILE (VIA C:D)

i. Monthly file for re-certification (XXXXXX.REVIEW.FILE) is prepared by the fifth (5)th of each month. The other (XXXXXX.REVIEWC.FILE) is created around the seventeenth (17)th of each month. The recertification files contain the MCO's recipients whose Medicaid eligibility will be up for recertification (review/re-determination/renewal) in one (1) month.

i. XXXXXX.IMMUN.FILE (VIA C:D)

i. SCDHHS gets the immunization file from DHEC around the second (2)nd Monday of the month. In the file includes all the MCO’s eligible recipients that possess a record at DHEC of getting a shot. There are no date parameters on this file and

contains all shots on record at DHEC for the recipients. After DHHS receives the file, it will upload for each MCO.

j. XXXXXX.RSS2170 (VIA C:D)
    i. This is the daily membership file sent every weekday to each MCO with any changes to their membership. Sent by Maximus to each plan.
k. Monthly Files for Pricing Information And Procedure Codes
    i. These files are prepared by the fifth (5)th of each month and are sent via connect direct.
    ii. These files include:
        1. CAR.CODE – list of carrier codes RATE.FILE – provider contract rates
        2. FEE.SCHD – contains only currently active procedure codes
        3. PROCEDRE.CODE – contains any and all procedure codes including both currently active procedure codes and previously active procedure codes. This is what you should be using to verify any procedure codes before using the PROC-CODE-EDIT-IND.
l. XXXXXX.NPI.CRSSJUNC (VIA C:D)
    i. This is the NPI Crosswalk Junction file sent every weekday to each MCO.

V. Notification

a. The MCO is required to notify DHHS, via E-mail, when files are ready to be processed. DHHS will notify the MCO, via E-mail, when files are ready for the MCO to download. The exception to this is, there is no notification for HIPAA/EDI transactions. Details of this process will be exchanged at time of business startup. DHHS will provide an address for messages to be addressed to. The MCO will need to provide an address for DHHS to send messages to.

VI. HIPPA File Naming Convention

a. RUNNUMBER.EDI where 'RUNNUMBER' = an eight (8) digit number assigned by the translator when the file is put in the mailbox. This number has no intelligence associated with it. They are usually sent out the first (1)st Tuesday of every month after the payment run.
b. A submitter ID is required to exchange HIPAA EDI files.
c. An 834 transaction file is utilized. A cumulative 834 is sent from SCDHHS to Maximus every month. Maximus then breaks out all the recipients for each MCO and MHN and sends an 834 to each MCO and MHN.

Overview of Dates of Exchanged Files	
Files to SCDHHS from MCO	
File Name	**Due Date**
PROVIDER FILE	To be sent with encounter submission, but not required.
TPL FILE	8th of every month.
ENCOUNTER FILE	No later than the 25th of the month.
WRAP PAYMENT SUMMARY FILE	No later than the 25th of the month. Send a blank/empty file if there are no wrap records to report.
CAPITATED PAYMENT FILE	No later than the 25th of the month. Send a blank/empty file if there are no capitated records to report.
CAPITATED PAYMENT VOID FILE	Only submitted if there is a negative net amount for a provider in the Capitated payment file. This file is not required. If no capitated voids, do not send a file or a control file.
Files to MCO from SCDHHS.	
PROVIDER FILE	2 to 3 business days after MGC cutoff.
CLAIMS HISTORY	2 to 3 business days after MGC cutoff. GAP claims history will be sent around the 5th of the month.
MLE FILE	Sent during the MGC cutoff run. A second MLE file will be sent on the 1st of every month, which includes members added between cutoff and the end of the month.
834	Sent during MGC cutoff. There is no notification email.
EPSDT FILE	Sent at the end of every month.
CARRIER CODES FILE	Sent by the 5th of every month.
CONTRACT RATES FILE	Sent by the 5th of every month.
FEE SCHEDULE FILE	Sent by the 5th of every month.
RECERTIFICATION FILE	Sent by the 5th of every month.
820	Sent to the MCO's HIPAA mailbox the Tuesday following MGC cutoff.
IMMUNIZATION FILE	Sent the second Monday of every month.
DAILY MEMBERSHIP FILE	Sent daily on all weekdays; excludes Saturday and Sunday.
277	Sent after EDI files have been uploaded (except for NCPDP which don’t get a compliance 277) and after encounter files have processed (277 containing the edits).
ENCOUNTER HISTORY FILE	Sent by the 5th of every month.
ENCOUNTER VOID HISTORY FILE	Sent by the 5th of every month.
NPI CROSSWALK/ JUNCTION FILE	Sent daily on all weekdays; excludes Saturday and Sunday.

Claims File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
1.	Recipient ID	10	1	10	C	
2.	Filler	1	11	11		
3.	Claim-Indicator	1	12	12		'M' – Verified MHN claim – Recipient is member of a MHN on date of service on the claim. This will be the only indicator found in the sure MHN monthly files. Is not valid for MCO files, or history files. 'H' – Verified MCO claim – Recipient is a member of a MCO on the date of service on the claim. Is not valid for MHN files, or history files. 'S' - History Claim – Recipient was a current member of the MCO or MHN at run time. Their claims are provided for information.
4.	ICD-10 INDICATOR	1	13	13	C	VALUE 9 = ICD-9 VALUE 0 = ICD-10
5.	Recipient Pay Category	2	14	15	C	Table 01 – Assistance Pay Category – at time of claim
6.	Filler	1	16	16		
7.	Recipient RSP code1	1	17	17	C	Table 02 – RSP (Recipient Special Program) Codes
8.	Filler	1	18	18		
9.	Recipient RSP code2	1	19	19	C	Table 02- Note: If any of the RSP fields (3-9) = '5' then the recipient was in a MHN at the date of service of this claim.

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
10.	Filler	1	20	20		
11.	Recipient RSP code3	1	21	21	C	Table 02- Note: If any of the RSP fields (3-9) = '5' then the recipient was in a MHN at the date of service of this claim.
12.	Filler	1	22	22		
13.	Recipient RSP code4	1	23	23	C	Table 02
14.	Filler	1	24	24		
15.	Recipient RSP code5	1	25	25	C	Table 02
16.	Filler	1	26	26		
17.	Recipient RSP code6	1	27	27	C	Table 02
18.	Filler	1	28	28		
19.	Recipient County	2	29	30	C	Table 03 - County Codes-residence County at time of claim
20.	Filler	1	31	31		
21.	Recipient Qualifying Category	2	32	33	C	Table 04 - Qualifying Category – at time of claim
22.	Filler	1	34	34		
23.	Recipient Date of Birth	6	35	40	C	YYMMDD
24.	Filler	1	41	41		
25.	Recipient Sex	1	42	42	C	Table 12 – Gender
26.	Filler	1	43	43		
27.	Claim Control #	16	44	59	C	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
28.	Filler	1	60	60		
29.	Claim Type	1	61	61	C	See table 5 – Claim Type
30.	Filler	1	62	62		
31.	Type of Bill	1	63	63	C	M=Medicaid, X=Crossover
32.	Filler	1	64	64		
33.	From Date of Service	6	65	70	C	YYMMDD Claim Type Z: Admit Date Claim Type J: Premium Date Claim Type G: First DOS = From All others: Date of Service=FROM
34.	Filler	1	71	71		
35.	To Date of Service	6	72	77	C	YYMMDD Claim Type Z: Discharge Date = TO Claim Type J: Effective Date of any change Claim Type G: First DOS = TO All others: Date of Service=TO
36.	Filler	1	78	78		
37.	Date Paid	6	79	84	C	YYMMDD
38.	Filler	1	85	85		
39.	Paid Amount	10	86	95	N	9999999.99 Claim Type D,Z,J,G: Total Paid – Claim All others: Total Paid – Line
40.	Filler	1	96	96		
41.	Charged Amount	10	97	106	N	9999999.99 Claim Type D,Z,J,G: Total Charged – Claim All others: Total Charged for Line
42.	Filler	1	107	107		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
43.	Amt received - other (TPL)	10	108	117	N	9999999.99 Claim Type G (Nursing Home): Patient income applied to bill. All others claim types – Any other amt received. CLAIM Level field, not line i.e. for HIC & Dental, use only 1 per claim
44.	Filler	1	118	118		
45.	Claim Copayment Amount	8	119	126	N	99999.99 A(HIC), (B)Dental - Line Level; D(Drug), (Z) UB92 - Claim Level
46.	Filler	1	127	127		
47.	Line number	2	128	129	C	A (HIC) B (Dental) - Line number D - Medically necessary (field 1) Values: Y=YES, N or Blank or zero = NO All others: not used, will be 01
48.	Filler	1	130	130		
49.	Payment Message Indicator	1	131	131	C	Table 16 – Payment Messages HIC – Payment Message indicator (determines how surgical claim is paid. DRUG – Brand name medically necessary code DENTAL – Oral surgery indicator UB92 - Reimbursement Type
50.	Filler	1	132	132		
51.	Service Code	11	133	143	C	A (HIC), B(DENTAL) – Procedure Subfile & Code (first 6 bytes) Subfile = Table 6, Procedure Code – File 1 D (DRUG) - NDC code (all 11 bytes) - File 6 – NDC Drug Code Z (UB92) – attending MD UPIN if present
52.	Filler	1	144	144		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
53.	Proc code modifier	3	145	147	C	A (HIC), B (DENT) – Procedure Code Modifier -Table 7 Z (UB92) - Type of Bill - Table7Z
54.	Filler	1	148	148		
55.	Place of service	2	149	150	C	A (HIC) - 2 byte place of service Table 8 B (DENT) - 1 byte place of service Table 8 Z (UB92) - Patient Status Table 8 Z All others – not used
56.	Filler	1	151	151		
57.	Units	4	152	155	N	A (HIC), B (DENT) - units D (DRUG) – Quantity Z (UB92) - Inpatient - Covered Days G (NH) - Total days All Others – not used
58.	Filler	1	156	156		
59.	Diagnosis code Primary	6	157	162	C	A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes D (DRUG) - Therapeutic Class if present – Table 19
60.	Filler	1	163	163		
61.	Diagnosis code Second	6	164	169	C	A (HIC), B (DENT), Z (UB92): File #2 – Diagnosis Codes D (DRUG) – Generic Class if present
62.	Filler	1	170	170		
63.	Diagnosis code Admit	6	171	176	C	Z (UB92) only - Admit diagnosis: File #2 – Diagnosis Codes
64.	Filler	1	177	177		
65.	Funding code-1	2	178	179	C	File # 3 Fund Codes – valid for all claim types

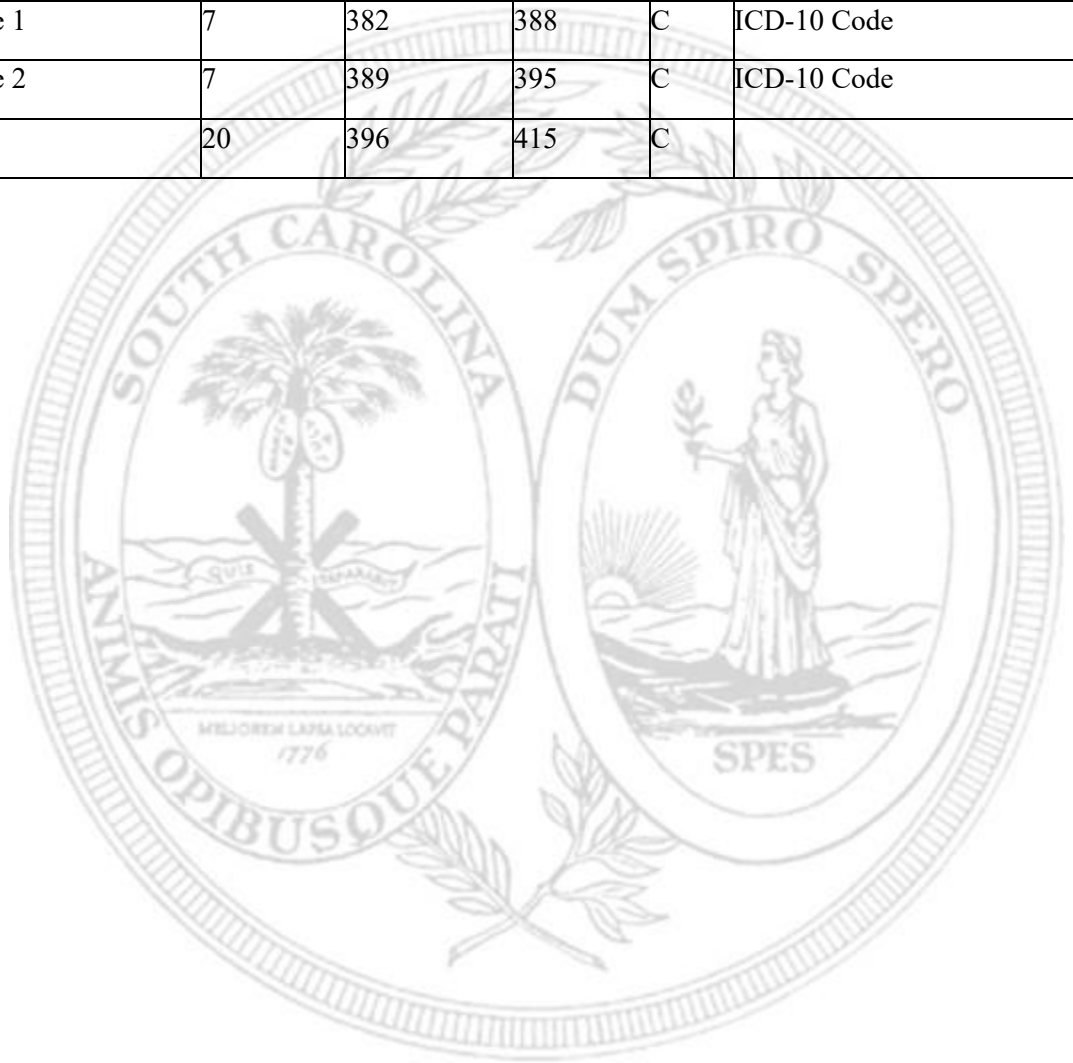
Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
66.	Filler	1	180	180		
67.	Funding code-2	2	181	182	C	File # 3 Fund Codes - valid only for hospital claims
68.	Filler	1	183	183		
69.	Funding code-3	2	184	185	C	File # 3 Fund Codes - valid only for hospital claims
70.	Filler	1	186	186		
71.	Paid Provider #	6	187	192	C	Provider Paid for the Services File # 4 and # 8 – Provider and Provider Group Affiliations
72.	Filler	1	193	193		
73.	Paid Provider Type	2	194	195	C	Table # 9 – Provider Types
74.	Filler	1	196	196		
75.	Paid Provider Specialty	2	197	198	C	Table # 10 – Provider Specialty
76.	Filler	1	199	199		
77.	Servicing Provider #	6	200	205		A (HIC) and B (DENT) – Provider of services All others – same as Paid Provider File # 4 and # 8 – Provider and Provider Group Affiliations
78.	Filler	1	206	206		
79.	Servicing Prov Type	2	207	208	C	A (HIC) and B (DENT): Provider of services All others – same as Paid Provider Table # 9 – Provider Types
80.	Filler	1	209	209		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
81.	Servicing Prov Specialty	2	210	211	C	For A (HIC) and B (DENT) – provider of services UB92, BIO – Category of Service of Paid Provider – Table 20 All others – same as Paid Provider Table # 10 – Provider Specialty
82.	Filler	1	212	212		
83.	Prescriber ID	6	213	218	C	Prescriber Medicaid # f present. Note: All the prescriber fields (83-89) are unreliable. They are reserved for future use.
84.	Filler	1	219	219		
85.	Prescriber ID-Type	2	220	221	C	Prescriber Provider Type if present. Note: All the prescriber fields (83-89) are unreliable. They are reserved for future use.
86.	Filler	1	222	222		
87.	Prescriber ID-SSN	9	223	231		Prescriber SSN if present. Note: All the prescriber fields (83-89) are unreliable. They are reserved for future use.
88.	Filler	1	232	232	C	
89.	Prescriber ID-NAPB	7	233	239	C	Prescriber NABP if present. Note: All the prescriber fields (83-89) are unreliable. They are reserved for future use Note:
90.	Filler	1	240	240		
91.	Refill # (blank if orig)	2	241	242	C	Blank or zeroes if original RX, otherwise # refills
92.	Filler	1	243	243		
93.	Days Supply	3	244	246	N	
94.	Filler	1	247	247		
95.	DRG	3	248	250	C	File # 6 – DRG Codes

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
96.	Filler	1	251	251		
97.	Outpt Visit Type	1	252	252	C	E=emergency room , Table # 11 Outpatient visit codes
98.	Filler	1	253	253		
99.	ICD9 Surgical Code 1	6	254	259	C	File # 7, Surgical Codes
100.	Filler	1	260	260		
101.	ICD9 Surgical Code 2	6	261	266	C	File # 7, Surgical Codes
102.	Filler	1	267	267		
103.	ER Revenue Code	3	268	270	C	ER Revenue code. N/A unless field #49 is equal to “E” (i.e. the claim is an ER claim)
104.	Filler	1	271	271		
105.	Provider Own Reference #	15	272	286	C	A (HIC) B (DENT) G (NH) – Provider own reference D (DRUG) – Prescription number Z (UB92) – Medical Records number
106.	Filler	1	287	287		
107.	Paid Provider Ownership Code	3	288	290	C	Table #18 – Provider Ownership
108.	Filler	1	291	291		
109.	Prescriber Number	10	292	301	C	Match to file on DHHS Drug Website # assigned to a physician which is used to identify the prescriber.
110.	Filler	1	302	302		
111.	HIC- Authorization Number	8	303	310	C	Prior authorization # for Claim Type A

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
112.	Filler	1	311	311		
113.	Provider County	2	312	313	C	Provider county Table 3 – County codes
114.	Filler	1	314	314		
115.	Prior Authorization Number 1	13	315	327	C	Prior Authorization # for Claim Type B
116.	Filler	1	328	328		
117.	Prior Authorization Number 2	7	329	335	C	Prior Authorization number 2
118.	Filler	1	336	336		
119.	MHN/MCO Provider number	6	337	342	C	For sure claims (PCCM indicator = M or H) this is the MHN or MCO the recipient is a member of at the date of service. For history claims (PCCM indicator = S) this is the MHN or MCO the recipient is a current member of.
120.	Filler	1	343	343		
121.	Check Number	7	344	350	C	
122.	Filler	1	351	351		
123.	Gatekeeper Physician	6	352	357	C	Valid for MHN sure claims only (PCCM indicator = M) – This is the physician number of the gatekeeper at the date of service of the claim.
124.	Filler	3	358	360	C	Reserved for future use
125.	ICD-10 Primary Diagnosis	7	361	367	C	ICD-10 Code
126.	ICD-10 Secondary Diagnosis	7	368	374	C	ICD-10 Code
127.	ICD-10 Admitting Diagnosis	7	375	381	C	ICD-10 Code

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
128.	ICD-10 Surgery Code 1	7	382	388	C	ICD-10 Code
129.	ICD-10 Surgery Code 2	7	389	395	C	ICD-10 Code
130.	Filler	20	396	415	C	



Special Instruction for the Claims File Layout:

1. All records must be fixed length
2. Column N/C;
    a. N = Numeric – All numeric fields are right justified and zero filled to left
        i. EX: 5 bytes 123 will appear as 00123
    b. Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
        i. EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
    c. C = Character – All character fields are left justified and space filled to the right Unless otherwise specified there will be no signed fields.

DHEC Immunization File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
1.	Medicaid ID	10	1	10	N	Recipient Medicaid ID
2.	Insurance Co ID	20	11	30	C	Not used – Value Spaces
3.	Last Name	30	31	60	C	
4.	First Name	20	61	80	C	
5.	Date Of Birth	8	81	88	C	MASK: YYYYMMDD
6.	Date of Shot	8	89	96	C	MASK: YYYYMMDD
7.	Shot Name	30	97	126	C	Name of the shot. Beginning of the field is the CPT code.
8.	Filler	24	127	150		Value Spaces

Special Instruction for the DHEC Immunization File Layout:

1. All records must be fixed length:
2. Column N/C;
    a. N = Numeric – All numeric fields are right justified and zero filled to left
        i. EX: 5 bytes 123 will appear as 00123
    b. Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
        i. EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0044297. The decimal is 'implied' and will not be included.
    c. C = Character – All character fields are left justified and space filled to the right Unless otherwise specified there will be no signed fields

This is a special interface with DHEC. It is to provide a file to DHEC, in HHCD011 named DHEC.IMMUN, which will pass against their files and return immunization information.

The returned file will be passed to Thomson. This is a job which will pick up the DHEC.IMMUN.IN file in HHCD011 and copy it to HHSCDR3 named DSU.DHEC.IMMUN.IN.

This file may eventually need to be transferred to ORS. As of 11/13/09 no decision has been made on this. If the file is transferred to ORS, then the file would need to be copied to HHCD006 and named DHEC.IMMUN.IN.

MCO Member File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
1.	MLE-RECORD-TYPE	1	1	1	C	Internal, H=HMO, P=PEP, C=MHN, ? = Other
2.	MLE-CODE	1	2	2	C	Status in Managed Care: A – AUTO ENROLLED; R - RETROACTIVE N – NEW; P – PREVIOUSLY ENROLLED WITH SAME PHYSICIAN C – CONTINUING; D – DISENROLLED M – MATERNITY KICKER
3.	MLE-PROV-NO	6	3	8	C	Physician recipient is enrolled with.
4.	MLE-PROV-NAME	26	9	34	C	Provider Name
5.	MLE-CAREOF	26	35	60	C	Provider Address
6.	MLE-STREET	26	61	86	C	Provider Street
7.	MLE-CITY	20	87	106	C	City
8.	MLE-STATE	2	107	108	C	State
9.	MLE-ZIP	9	109	117	C	Zip code + 4
10.	MLE-RECIP-NO	10	118	127	C	Recipient identifying Medicaid number.
11.	MLE-RECIP-LAST-NAME	17	128	144	C	Recipient Last name
12.	MLE-RECIP-FIRST-NAME	14	145	158	C	Recipient First name
13.	MLE-RECIP-MI	1	159	159	C	Recipient Middle initial
14.	MLE-ADDR-CARE-OF	25	160	184	C	Recipient address
15.	MLE-ADDR-STREET	25	185	209	C	Street

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
16.	MLE-ADDR-CITY	23	210	232	C	City
17.	MLE-ADDR-STATE	2	233	234	C	State
18.	MLE-ADDR-ZIP	9	235	243	C	Zip code + 4
19.	MLE-ADDR-AREA-CODE	3	244	246	C	Recipient phone number Area code
20.	MLE-ADDR-PHONE	7	247	253	C	Recipient phone number
21.	MLE-COUNTY	2	254	255	C	Recipient county where eligible
22.	MLE-RECIP-AGE	3	256	258	N	Recipient Age
23.	MLE-AGE-SW	1	259	259	C	Values: 'Y' = Year 'M' = Month '<' = Less than 1 month 'U' = Unknown
24.	MLE-RECIP-SEX	1	260	260	C	Values: '1' = Male '2'= Female '3' = Unknown
25.	MLE-RECIP-PAY-CAT	2	261	262	C	Recipient category of eligibility – see Table 01 for values
26.	MLE-RECIP-DOB.	8	263	270	C	Recipient date of birth Mask: CCYYMMDD
27.	MLE-ENROLL-DATE	6	271	276	C	MCO Enrollment Date Mask: YYMMDD
28.	MLE-DISENROLL-DATE	6	277	282	C	MCO Disenrollment Date Mask: YYMMDD

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
29.	MLE-DISENROLL-REASON	2	283	284	C	Reason Code for Disenrollment: 01- NO LONGER IN MCO PROGRAM 02- TRANSFERRED TO ANOTHER MANAGED CARE PROVIDER 03- MEDICAID ELIGIBILITY TERMINATED 04- HAS MEDICARE OR IS >= 65 YEARS OF AGE 05- CHANGE TO NON-MEDICAID PAYMENT CATEGORY 06- MANAGED CARE PROVIDER TERMINATED 07- OCWI (PEP AND PAYMENT CATEGORY 87) -8- RECIPIENT HAS TPL HMO POLICY
30.	MLE-PR-KEY	3	285	287	C	Premium Rate Category
31.	MLE-PREMIUM-RATE	9	288	296	N	Amount of Premium paid Mask: S9(7)v99
32.	MLE-PREM-DATE.	6	297	302	C	Month for which the premium is paid. Mask: CCYYMM
33.	MLE-MENTAL-HEALTH- ARRAY	3	303	305	C	Obsolete
34.	MLE-PREFERRED-PHYS	25	306	330	C	Recipient’s preferred provider
35.	MLE-REVIEW-DATE-CCYYMMDD.	8	331	338	C	Date recipient will be reviewed for eligibility and/or managed care enrollment. Mask: CCYYMMDD
36.	PREGNANCY-INDICATOR	1	339	339	C	Pregnancy indicator Values: ‘Y’ = Yes ‘ ‘ = No
37.	MLE-SSN	9	340	348	C	Member’s social security number
38.	TPL-NBR-POLICIES	2	349	350	C	Number of TPL policies
39.	TPL INFORMATION below REPEATS 10 TIMES IF APPLICABLE This occurs only 5 times on the 834	4140	351	4490		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
40.	POLICY-CARRIER-NAME	50	351	400	C	Policy carrier name
41.	POLICY-NUMBER	25	401	425	C	Policy number
42.	CARRIER-CODE	5	426	430	C	Code to signify a carrier
43.	POLICY- RECIP-EFFECTIVE DATE	8	431	438	C	Recipient policy effective date Mask: CCYYMMDD
44.	POLICY-RECIP-LAST UPDATE	6	439	444	C	Recipient policy last update Mask: YYMMDD
45.	POLICY-RECIP-OPEN DATE	8	445	452	C	Recipient policy open date Mask: CCYYMMDD
46.	POLICY-RECIP-LAPSE DATE	8	453	460	C	Recipient lapse date policy Mask: CCYYMMDD
47.	POLICY-RECIP-PREG-COV- IND	1	461	461	C	Pregnancy coverage indicator
48.	POLICY-TYPE	2	462	463	C	Type of policy-health or casualty
49.	POLICY-GROUP-NO	20	464	483	C	Policy group number
50.	POLICY-GROUP-NAME	50	484	533	C	Policy group name
51.	POLICY-GROUP-ATTN	50	534	583	C	Policy group attention
52.	POLICY-GROUP-ADDRESS	50	584	633	C	Policy group address
53.	POL-GRP-CITY	39	634	672	C	Policy group city
54.	POL-GRP-STATE	2	673	674	C	Policy group state
55.	POL-GRP-ZIP	9	675	683	C	Policy group zip code + 4
56.	POL-POST-PAYREC-IND	1	684	684	C	Values: ‘0’ = cost avoid ‘1’ = no cost avoid
57.	POLICY-INSURED-LAST NAME	17	685	701	C	Insured last name

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
58.	POLICY-INSURED-FIRST NAME	14	702	715	C	Insured first name
59.	POLICY-INSURED-MI-NAME	1	716	716	C	Insured middle Initial
60.	POLICY--SOURCE-CODE	1	717	717	C	Source of info about policy (ie. champus, highway)
61.	POLICY--LETTER-IND	1	718	718	C	If present, pass group address info
62.	POL-EFFECTIVE-DATE	8	719	726	C	Effective date of policy Mask: CCYYMMDD
63.	POL-OPEN-DATE	8	727	734	C	First stored date Mask: CCYYMMDD
64.	POL-COVER- IND-ARRAY	30	735	764	C	Occurs 30 Times 1 BYTE FIELDS of what policy will cover Values: A = HOSP-INPAT B = HOSP-OUT C = SURGERY D = ANESTHESIA F = DOCT-VISIT G = DIAG-TEST H = C/A-DRUG I = RETRO-DRUG J = PHYS-THRPY K = EYE-EXAM L = GLASSES M = PSYCH-IN N = PSYCH P = HOME-CARE Q = DIALYSIS R = AMBULANCE S = DME U = NH-SKILLED V = NH-INTER X = ORAL-SURG Y = DENTAL

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
65.	RECIPIENT-RACE	2	4491	4492	C	Race code - Reference Table 13
66.	RECIPIENT-LANGUAGE	1	4493	4493	C	Language code -Reference Table 21
67.	RECIPIENT-FAMILY--NUM	8	4494	4501	C	Family Number
68.	NEWBORN-RECIPIENT-ID	10	4502	4511	C	Newborn Medicaid ID
69.	PREMIUM-AGE	3	4512	4514	N	Recipient Age For Premium Calculations
70.	PREMIUM-AGE-INDICATOR	1	4515	4515	C	Values: ‘Y’ = Year; ‘M’ = Month
71.	FILLER	85	4516	4600	C	Filler

Special Instruction for the MCO Member File Layout:

1. All records must be fixed length
2. Column N/C;
    a. N = Numeric – All numeric fields are right justified and zero filled to left
        i. EX: 5 bytes 123 will appear as 00123
    b. Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
        i. EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
    c. C = Character – All character fields are left justified and space filled to the right Unless otherwise specified there will be no signed fields

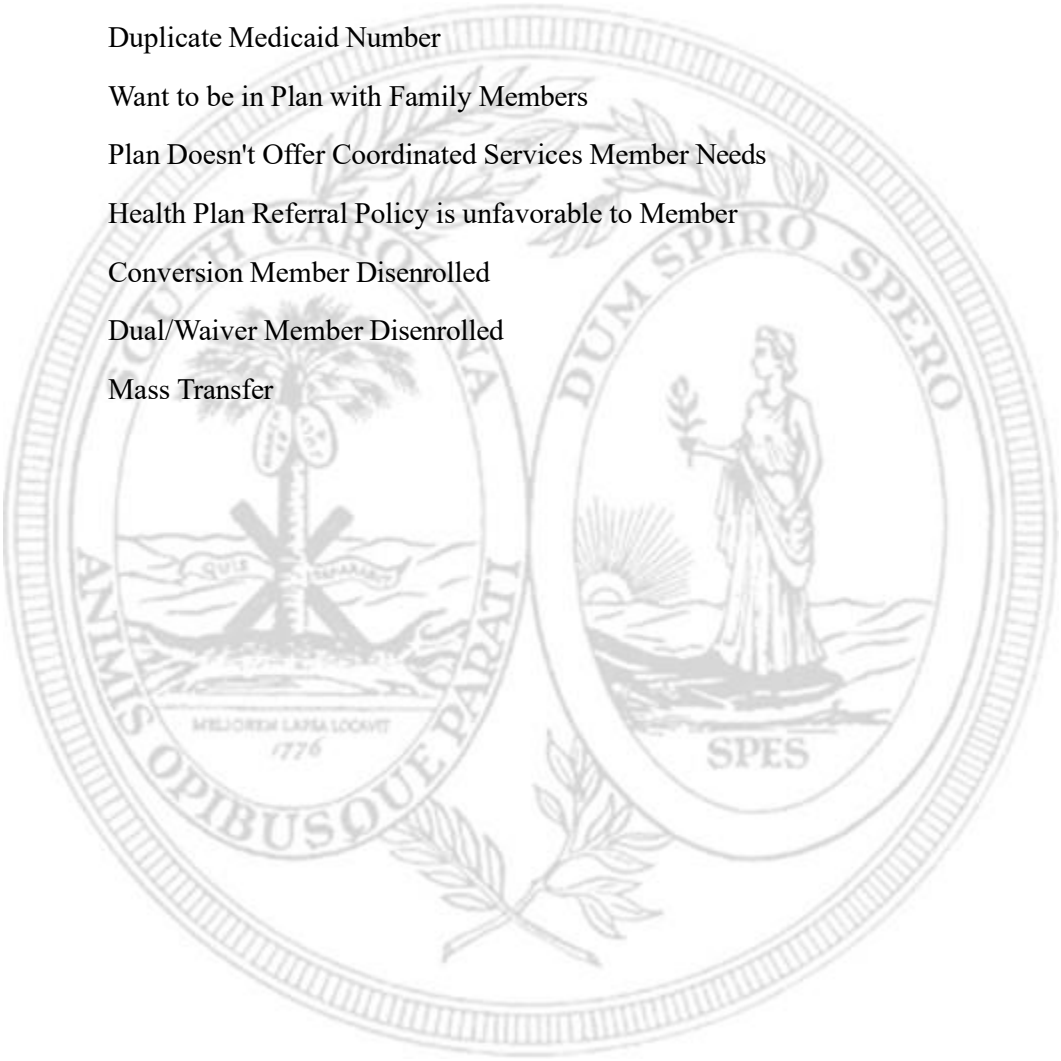
Enrollment Reason Codes Used by Enrollment Broker

Code	Description
649	Online Member Enrollment
650	Auto Enrollment
651	Member Choice
652	Member Choice Change
653	Change Override
654	Health Plan Re-enrollment
655	Auto Enrolled - Other Family in PCP
656	Newborn Auto- Mother's Plan
657	Member Change for Moral or Religious Reasons
658	Member Change to Same Plan as Family
660	Member Change Due to Poor Quality of Care
661	Health Plan Historic Enrollment
662	Member Reassigned - Service Not Provided
663	Member's New Choice During Annual Enrollment
664	Member Reassigned Due to Abuse or Fraudulent Utilization of Services
666	PCP Historic Enrollment
667	Auto Enrollment-PCP Only
668	Family Member Plan
669	Prior Member Plan
680	Duplicate Medicaid Number
688	Auto Enrollment - Other Members in Plan
689	Auto Enrolled- Past Case History
694	Member's New Choice During Deferred Annual Enrollment
891	Conversion Member Transferred to New Health Plan
892	Conversion Member Assigned to Different Plan
899	Mass Change Assignment

Disenrollment Reason Codes Used by Enrollment Broker

Code	Description
3	Member Ineligible for Medicaid
4	Member Eligible for Medicare
5	Member Pay Cat Inconsistent with Managed Care
6	Managed Care Provider Terminated
8	Member Has Private HMO Coverage
10	Provider No Longer Participates In PCCM
11	MHN Board Provider Terminated
30	Moved Out of Plan Service Area
31	Got Poor Quality Care
34	Lack of Access to Services Covered Under the contract
35	Doctor Not Part of Network
36	Lack of Access to Providers Experienced with Member's Health C
37	Entering A Waiver Program
38	Entering Hospice
39	Not Able To Get The Medicines I Was Able To Get In Regular Med
40	Entering Nursing Home
41	Other (Requires Additional Note on Exact Reason)
42	No reason provided on enrollment form
53	Didn't Realize What I was Signing Up For
55	Member Changed from Medicaid to HCK
56	Member Changed from HCK to Medicaid
60	Member Died
61	Member Is Incarcerated
65	Member No Longer Meets Criteria to Participate in Managed Care
65	Member No Longer Meets Criteria to Participate in Managed Care
66	Member Fails to Follow the Rules of the Plan
67	Member's Behavior is Disruptive, Unruly, Abusive or Uncooperative

70	Member Placed Out of Home
75	Pharmacy Not Part of Network
80	Duplicate Medicaid Number
83	Want to be in Plan with Family Members
84	Plan Doesn't Offer Coordinated Services Member Needs
85	Health Plan Referral Policy is unfavorable to Member
91	Conversion Member Disenrolled
92	Dual/Waiver Member Disenrolled
98	Mass Transfer



Non-Par Provider File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
1.	HMO-MEDICAID-NUM	6	1	6	C	Managed care plan Medicaid number
2.	PROVIDER-ID-NUMBER	6	7	12	C	Identifies a provider or group provider who is not enrolled as a Medicaid provider. The 1st byte of the number must be the symbol assigned that will identify the MCO on our database. You must use a new, unique ID for each provider. If a provider has several different specialties, you must have a new, unique ID for each specialty. DO NOT USE AN ID MORE THAN ONCE.
3.	PROVIDER-NAME	26	13	38	C	Non-Medicaid Provider's Name
4.	PROVIDER-CAREOF	26	39	64	C	
5.	PROVIDER- STREET	26	65	90	C	
6.	PROVIDER-CITY	20	91	110	C	
7.	PROVIDER-STATE	2	111	112	C	
8.	PROVIDER-ZIP	9	113	121	C	
9.	PROVIDER-COUNTY	12	122	133	C	County Name
10.	PROVIDER-EIN-NUM	10	134	143	C	Provider identification number(tax ID)
11.	PROVIDER-SSN-NUM	9	144	152	C	
12.	PHARMACY-PERMIT-NUM	10	153	162	C	Pharmacy permit number -- DEA Number
13.	PROVIDER-TYPE	2	163	164	C	Refer to Table 09 for provider types

14.	PROVIDER-SPECIALTY	2	165	166	C	Refer to table for provider specialties
15.	PROVIDER-CATEG-SERV	2	167	168	C	Refer to table for categories of service
16.	PROVIDER-LICENSE- NUMBER	10	169	178	C	SC state license number
17.	PROVIDER-NPI	10	179	188	C	NPI for non-par providers
18.	PROVIDER-PHONE- NUMBER	10	189	198	C	
19.	TAXONOMY	10	199	208	C	
20.	FILLER	25	209	233		

Special Instruction for the Non-Par Provider File Layout:

1. Fields 1, 2, 3, 4(when applicable), 5, 6, 7, 8, 9, 10 (when applicable), 13, 14 and 17 are mandatory fields that must contain provider specific data. Provider data submission not containing this information will subject the MCOs to penalties.
2. All records must be fixed length:
3. Column N/C;
    a. N = Numeric – All numeric fields are right justified and zero filled to left
        i. EX: 5 bytes 123 will appear as 00123
    b. Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
        i. EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
    c. C = Character – All character fields are left justified and space filled to the right
    d. Unless otherwise specified there will be no signed fields

Output Record for Provider File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
1.	PROVIDER-ID-NUMBER	6	1	6	C	Medicaid provider number
2.	PROVIDER-NAME	26	7	32	C	
3.	PROVIDER-CAREOF	26	33	58	C	Provider address line 1
4.	PROVIDER- STREET	26	59	84	C	
5.	PROVIDER-CITY	20	85	104	C	
6.	PROVIDER-STATE	2	105	106	C	
7.	PROVIDER-ZIP	9	107	115	C	
8.	PROVIDER-PHONE- NUMBER	10	116	125	C	
9.	PROVIDER-COUNTY	12	126	137	C	Refer to table 03 for county codes
10.	PROVIDER-TYPE	2	138	139	C	Refer to table 09 for provider types
11.	PROVIDER-SPECIALTY	2	140	141	C	Refer to table 10 for provider specialties
12.	PROV-PRICING-SPECIALTY	2	142	143	C	
13.	PROVIDIER-NPI	10	144	153	C	
14.	FILLER	38	154	191	C	

Special Instruction for the Output Record for Provider File Layout:

1. All records must be fixed length:
2. Column N/C;
    a. N = Numeric – All numeric fields are right justified and zero filled to left
        i. EX: 5 bytes 123 will appear as 00123
    b. Mask will be shown as 99999V99 for fields with 'implied' decimal. 'V' represents the 'implied' position of the decimal.
        i. EX: Field is described as length of 7. Mask shows 99999V99. Amount being submitted is $442.97. Value in the record will be 0049297. The decimal is 'implied' and will not be included.
    c. C = Character – All character fields are left justified and space filled to the right
    d. Unless otherwise specified there will be no signed fields

Redetermination File Layout

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
1.	REV-FAMILY –NUMBER	8	1	8	C	Recipient identifying family number.
2.	Filler	1	9	9		
3.	REV-RECIP-NO	10	10	19	C	Recipient identifying Medicaid number.
4.	Filler	1	20	20		
5.	REV-RECIP-NAME	20	21	40	C	Recipient name, Last, First, Middle Initial
6.	Filler	1	41	41		
7.	REV-ADDR-STREET	25	42	66	C	
8.	Filler	1	67	67		
9.	REV-ADDR-CITY	20	68	87	C	
10.	Filler	1	88	88		
11.	REV-ADDR-STATE	2	89	90	C	
12.	Filler	1	91	91		
13.	REV-ADDR-ZIP	5	92	96	C	
14.	Filler	1	97	97		
15.	REV-ADDR-PHONE	15	98	112	C	
16.	Filler	1	113	113		
17.	REV-REVIEW-DATE	10	114	123	N	CCYY-MM-DD
18.	Filler	1	124	124		
19.	REV-REVIEW-MAILED	10	125	134	N	CCYY-MM-DD

20.	Filler	1	135	135		
21.	REV-PROVIDER-NO	6	136	141	C	
22.	Filler	1	142	142		
23.	REV-BOARD-PROV-NO	6	143	148	C	Applicable for medical home programs only
24.	Filler	1	149	149		
25.	REV-PAYEE-NAME	25	150	174	C	Name of payee for family
26.	Filler	1	175	175		
27.	REV-PAYEE-TYPE	3	176	178	C	Payee Type: See Note 1 below.
28.	Filler	1	179	179		
29.	REV-RECIP-PAY-CAT	2	180	181	C	Pay Categories: See Note 2 below.
30.	Filler	1	182	182		
31.	COUNTY-WORKER-FIRST- NAME	17	183	199	C	
32.	Filler	1	200	200		
33.	COUNTY-WORKER-LAST- NAME	26	201	226	C	
34.	Filler	1	227	227		
35.	COUNTY-WORKER-PHONE	10	228	237	C	
36.	Filler	1	238	238		
37.	COUNTY-WORKER-PHONE-EXTENSION	4	239	242	C	
38.	Filler	1	243	243	C	
39.	HOUSEHOLD NUMBER	9	244	252	C	Ties households together.
40.	Filler	48	253	300		

Special Instruction for the Redetermination File Layout:

1. All records must be fixed length:
2. Column N/C;
    a. N = Numeric – All numeric fields are right justified and zero filled to left
        i. EX: 5 bytes 123 will appear as 00123
    b. C = Character – All character fields are left justified and space filled to the right

Unless otherwise specified there will be no signed fields Logic for inclusion in this file is as follows:

```
WHERE  BG.BG_CDE_STATUS = 'A'

AND BG.BG_CDE_ACTION = 'R'

AND ((BG.BG_DTE_FORM_MAILED <= CURRENT DATE - 30 DAYS) OR
(BG.BG_DTE_FORM_MAILED IS NULL))

AND BG.BG_DTE_FORM_RECD IS NULL

AND BG.BG_NUM_PYMT_CATEGORY IN ('12','15','16','17','18',

'19','32','40','57','59','71','88')

AND BG.BG_UID_WORKER_ID = WKR.WKR_UID_WORKER_ID

AND BG.BG_NUM_BUDGET_GROUP_ID = HB.HBJ_NUM_BUDGET_GROUP_ID AND
BG.BG_NUM_BUDGET_GROUP_ID = BMJ.BMJ_NUM_BUDGET_GROUP_ID AND
MEH.MEH_NUM_MEMBER_ID = BMJ.BMJ_NUM_MEMBER_ID

AND MEH.MEH_NUM_BUDGET_GROUP_ID = BMJ.BMJ_NUM_BUDGET_GROUP_ID AND
MEH.MEH_DTE_INELIG IS NULL

AND WKR.WKR_CDE_COUNTY = LOC.LOC_CDE_COUNTY

AND WKR.WKR_CDE_LOCATION = LOC.LOC_CDE_LOCATION
```

Note 1: Payee Types for Field 27.

SEL SELF OR AFDC PAYEE

GDN LEGAL GUARDIAN

REL OTHER RELATIVE

AGY SOCIAL AGENCY

PPP PROTECTIVE PAYEE

REP REPRESENTATIVE PAYEE FOS INDICATES FOSTER CHILD SPO SPOUSE

INP LEGALLY INCOMPETENT, NO REPRESENT

Note 1: Payment Categories for Field 29.

MAO (NURSING HOMES)

MAO (EXTENDED TRANSITIONAL)

OCWI (INFANTS UP TO AGE 1)

MAO (FOSTER CARE/SUBSIDIZED ADOPTION)

MAO (GENERAL HOSPITAL)

MAO (CLTC)

PASS-ALONG ELIGIBLES

EARLY WIDOWS/WIDOWERS

DISABLED WIDOWS/WIDOWERS

DISABLED ADULT CHILD

PASS ALONG CHILDREN

AFDC (FAMILY INDEPENDENCE)

TITLE IV-E FOSTER CARE

AGED, BLIND, DISABLED

ABD NURSING HOME

WORKING DISABLED

MEDICAID REINSTATEMENT

S2 SLMB

S3 SLMB

QUALIFIED WORKING DISABLED (QWDI)

TITLE IV-E ADOPTION ASSISTANCE

SLMB (SPF LOW INC MEDCARE BENEFICIAR)

NOT CURRENTLY BEING USED

SSI NURSING HOMES

FAMILY PLANNING

COSY/ISCEDC

KATIE BECKETT CHILDREN - TEFRA

FI-MAO (TEMP ASSIST FOR NEEDY)

LOW INCOME FAMILIES

REGULAR FOSTER CARE

68 FI-MAO WORK SUPPLEMENTATION

70 REFUGEE ENTRANT

71 BREAST AND CERVICAL CANCER

80 SSI

81 SSI WITH ESSENTIAL SPOUSE

85 OPTIONAL SUPPLMENT

86 SUPPLEMENT & SSI

87 OCWI (PREGNANT)

88 OCWI (CHILD UP TO 19)

90 MEDICARE BENE(QMB)

91 RIBICOFF CHILDREN

92 ELIGIBLE FOR GAPS; NOT MEDICAID ELIGIBLE

APPENDIX C

REPORTS CHARTS

TABLE 1- Daily and As Necessary Report Requirements

Daily and As Necessary Reporting Requirements		
Managed Care Report Name	**Format**	**Report Timing**
Section 2		
Section 2.1		
Organizational Chart	Specific Format not defined MCO can utilize any format it chooses to present the data. Must be submitted within 10 business days of change in personnel.	Annually and Upon Change in Personnel
Section 2.2		
Personnel Resumes	Specific Format not defined MCO can utilize any format it chooses to present the data. Must be submitted for Key personnel within 10 business days of a change.	Upon Change in Key Personnel
Section 3		
Section 3.2		
834 Report Layout	MCO receives these reports on a daily basis providing information on membership enrollment.	Daily
Section 3.11		
Health Plan Disenrollment	Required for requesting member disenrollment can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary
Section 4		
Section 4.2		
Universal PA	Required for providers requesting most pharmaceuticals.	As Necessary

Universal Synagis PA	Required for providers requesting Synagis.	As Necessary
Section 4.3		
Additional Services	Required for requesting additional member services that an MCO would like to provide to encourage desired member outcomes	As Necessary
Section 4.8		
Member Incentives	Required for requesting additional member incentives that an MCO would like to provide to encourage desired member outcomes	As Necessary
Section 5		
Section 5.5		
Universal Newborn PA	Required for out-of-network pediatric providers to obtain an authorization for services rendered in the office during the first 60 days after discharge.	As Necessary
Section 7		
Section 7.3		
Premium Payment Adjustments	MCO's retroactive rate adjustment format.	As Necessary
Section 11		
Section 11.1		
Provider Notice	Form for reporting potential provider abuse fraud issues	As Necessary
Member Fraud and Abuse	Form for reporting potential member abuse and fraud issues	As Necessary
Beneficiary Explanation Of Medicaid Benefits (BEOMB)	Beneficiary Explanation of Medicaid Benefits (BEOMB) form for reporting instances where a member indicates that they did not receive a service from a provider.	As Necessary
MCO Payment Suspension	Uniform letter for payment suspensions for providers operating with an MCO	As Necessary
Provider Suspensions	SharePoint templates for reporting provider suspensions	As Necessary

Provider Exclusions	SharePoint templates for reporting provider exclusions	As Necessary
Provider Terminations	SharePoint templates for reporting provider terminations	As Necessary
Good Cause Exception (GCE)	Notifies the MCOs of a potential fraud referral for a provider of which they may request a payment suspension exception.	As Necessary
Permissions	To request permission to conduct a targeted BEOMB run.	As Necessary
Section 12		
Section 12.3		
Marketing Activities Submission Log	Log MCOs use to notify DHHS of upcoming marketing activities.	As Necessary
Section 16		
Section 16.3		
QA GRID	As necessary for the MCO to ask questions of their account manager.	As Necessary- Returned weekly to MCO

TABLE 2- Monthly Report Requirements

Monthly Reporting Requirements		
Managed Care Report Name	**Format**	**Report Timing**
Section 3		
Section 3.2		
Eligibility Redetermination	Report produced for MCO's when a Member is receiving Medicaid eligibility redeterminations completed by SCDHHS.	Monthly
Section 3.17		
Call Center Performance	Call center performance metrics for Member English language line, Member Spanish language line, and Provider call center.	Monthly
Section 4		
Section 4.2		
High Cost No Experience (HCNE) Drug	Reimbursement for high cost no experience pharmaceuticals	Monthly
Section 5		
Section 5.4		
Case Management	Report of all members receiving care management services on an ongoing basis with the MCO.	Monthly
Section 7		
Section 7.3		
Dual Medicare Medicaid	Report produced for the MCO's to account for retro-active dual eligible Medicare recoupments for up to a year in arrears.	Monthly
Manual Maternity Kicker	Maternity Kicker Form for use when automated process does not function correctly	Monthly
Monthly Premium Recoupment	Report produced for the MCOs for all members that received a premium payment in error.	Monthly
Patient Center Medical Home (PCMH)	MCO's submission is monthly; SCDHHS pays the MCO's on a quarterly basis. Utilized to reimburse those	Monthly

	primary care practices that qualify for this incentive payment.	
Section 10		
Section 10.9		
Third Party Liability (TPL) Verification	TPL Verification Report indicates those members the MCO indicates have third party insurance coverage. This report is submitted via the departments FTP site.	Monthly
Third Party Liability (TPL) Cost Avoidance	TPL cost avoidance report indicates those claims that the MCO has cost avoided during the month.	Monthly
Third Party Liability (TPL) COB Savings	TPL Coordination of Benefits (COB) report indicates those claims leading to coordination of benefits savings for the MCO.	Monthly
Third Party Liability (TPL) Recoveries	Recoveries that the MCO have made as a result of research for members with potential or known third party coverage.	Monthly
TPL Casualty Cases	Any casualty cases that the MCO is aware are ongoing.	Monthly
Section 11		
Section 11.1		
Termination Denial for Cause	Reporting of terminated providers that should be submitted directly to Program Integrity's SharePoint site.	Monthly
Section 13		
Table 13.1		
Claims Payment Accuracy	Report detailing monthly claim payment by the MCO.	Monthly
PRTF	Report detailing MCO members in or recently discharged from a PRTF.	Monthly
Section 14		
Section 14.5		
Encounter Submission Summary	Report detailing totals for monthly claims paid, accepted encounters, rejected encounters, and completeness percentage.	Monthly
Appendix E		

BabyNet Members	Report produced for the MCOs of members receiving BabyNet Services	Monthly
BabyNet Providers	Report produced for the MCOs of BabyNet Providers	Monthly

TABLE 3- Quarterly Reporting Requirements

Quarterly Reporting Requirements		
Managed Care Report Name	**Format**	**Report Timing**
Section 6		
Section 6.3		
Provider Network	MCO report sent to SCDHHS reflecting MCOs entire provider network.	Quarterly
Section 7		
Section 7.3		
MCO Withhold	Report template shared with the MCO to indicate quarterly withholding done to MCO's.	Quarterly
Section 7.4		
FQHC RHC Wrap Payments	Current FQHC/RHC reports required for wrap payment process.	Quarterly
Section 9		
Section 9.1		
Member Grievance and Appeal Log	Grievance and Appeal reporting required of the MCO.	Quarterly
Section 9.2		
Provider Dispute Log	Provider dispute reporting required of the MCO.	Quarterly
Section 11		
Section 11.1		
Quarterly MCO Fraud and Abuse	Quarterly reporting of fraud and abuse. This report should be submitted directly to Program Integrity's SharePoint site.	Quarterly
Section 13		
Section 13.1		

Graduate Medical Education (GME)	Report detailing payment for GME Providers and Institutions.	Quarterly
Section 14		
Section 14.10		
EQI	Encounter Quality Initiative	Quarterly, Annually

TABLE 4- Bi-Annual and Annual Reporting Requirements

Semi-Annual and Annual Reporting Requirements		
Managed Care Report Name	**Format**	**Report Timing**
Section 2		
Section 2.1		
Organizational Chart	Specific Format not defined. MCO can utilize any format it chooses to present the data. Must be submitted within 10 business days of change in personnel.	Annually and Upon Change in Personnel
Section 4		
Section 4.2		
Institution for Mental Disease (IMD)	Report provided to MCOs of members 21-64 with an IMD stay exceeding 15 days.	Annually
Section 7		
Section 7.2		
Medical Loss Ratio (MLR)	Medical Loss Ratio Calculation report indicating the proportion of premium revenues spent on clinical services and quality improvement.	Annual
Section 7.4		
FQHC RHC Wrap Payments Annual	Current FQHC/RHC reports required for wrap payment process Annual Reconciliation.	Annually
Section 7.9		
Annual Audited Financial Statement	Should be the same report produced for the SC Department of Insurance (SCDOI).	Annually
Section 9		
Section 9.1		
Member Grievance and Appeal Log	Grievance and Appeal reporting required of the MCO.	Annually
Section 11		
Section 11.1		

Annual Strategic Plan	Strategic Plan Matrix can be found at PI SharePoint site.	Annually
Section 11.2		
Written Compliance Plan	Compliance Plan Matrix can be found at PI SharePoint site.	Annually
Section 14.10		
EQI	Encounter Quality Initiative	Quarterly, Annually
Section 15		
Section 15.1		
Population Assessment Report	NCQA defined	Annually
Section 15.4		
HEDIS and CAHPS	NCQA defined	Annually
Section 15.5		
Alternative Payment Models (APM)	Alternative Payment Models	Annually

Milliman Reports

The following is a list of reports or data files that the MCO either sends directly to Milliman or is received directly by Milliman, on behalf of DHHS. These reports are utilized for various Managed Care services and assist in capturing data to maintain current Managed Care contract requirements.

South Carolina Department of Health and Human Services					
Milliman-MCOs Recurring Report List					
Report Name	**Description**	**Frequency**	**Timeframe**	**Currently Included in Companion Guide?**	**Notes**
To MCOs					
Supplemental Teaching Physician (STP) Directed Payment	Reports provided to each MCO with quarterly payment amounts directed to providers; final reconciliation occurs six months after completion of the SFY.	Quarterly	Quarterly and following completion of the SFY	No	Schedule described in P&P Section 7.4.
Independent Community Pharmacy Dispensing Fee Directed Payment	Reports provided to each MCO with quarterly payment amounts directed to pharmacies by NPI; final reconciliation occurs three months after completion of the SFY.	Quarterly	Quarterly and following completion of the SFY	No	Schedule described in P&P Section 7.12.
Quality Withhold Reporting	Report provided to each MCO to indicate quarterly capitation revenue withheld as part of the quality withhold program.	Quarterly	Following completion of each quarter	Yes	

Institution for Mental Diseases (IMD) Greater than 15 Days	Report provided to each MCO containing members 21- 64 with an IMD stay exceeding 15 days and associated capitation recoupments.	Annually	Provided approximately eight months following completion of the SFY.	Yes	Uses six months of claims runout.
PRTF Risk Pool Reconciliation	Report provided to each MCO containing reconciliation of MCO payment to/from the PRTF risk pool established in SFY 2023.	Annually	Provided approximately eight months following completion of the SFY.	No	Uses six months of claims runout.
From MCOs					
MCO Rate Setting Survey	MCOs provide responses to a set of survey questions prepared by Milliman to support capitation rate development.	Annually	January-February	No	
Encounter Quality Initiative (EQI)	MCOs provide summarized encounter data in accordance with MCO Contract Section 14.10.	Quarterly	Quarterly CY-based submissions and annual SFY submission	Yes	Schedule described in P&P Section 14.10.
Minimum Medical Loss Ratio (MLR) Reporting	MCOs provide summarized financial information indicating the proportion of premium revenues spent on clinical services and quality improvement in accordance with MCO Contract Section 7.2	Annually	Following completion of the SFY	Yes	Schedule described in MCO contract Section 7.2.1.

Maximus Reports

The following is a list of reports or data files that the MCO either sends directly to Maximus or is received directly by Maximus, on behalf of DHHS. These reports are utilized for various Managed Care services and assist in capturing data to maintain current Managed Care contract requirements.

South Carolina Department of Health and Human Services Maximus-MCOs Recurring Report List					
Report Name	**Description**	**Frequency**	**Timeframe**	**Sender**	**Receiver**
834 File					
834 daily (MCO and Prime)	Combined (MCO+Prime) file of confirmed transactions and demographic data relayed from SCDHHS to health plans	Tuesday-Sunday	Daily	Maximus	Health Plans (MCO and Prime)
834 gap out (MCO)	Enrollment transactions for gap period from cutoff through the 1st of month, relayed from SCDHHS to health plans	Monthly	1st of every month	Maximus	Health Plans (MCO)
834 monthly cutoff out (MCO)	Roster file of transactions for all confirmed beneficiaries effective the start of the upcoming month	Monthly	MGC Saturday	Maximus	Health Plans (MCO)
834 monthly cutoff out (Prime)	Roster file of transactions for all confirmed beneficiaries effective the start of the current month	Monthly	1st Saturday of the month on or after the 4th	Maximus	Health Plans (Prime)
Control File accompanying 834 daily (MCO and Prime)	Email containing summary counts of corresponding file	Tuesday-Sunday	Daily	Maximus	Health Plans (MCO and Prime)
Control File accompanying 834 gap out (MCO)	Email containing summary counts of corresponding file	Monthly	1st of every month	Maximus	Health Plans (MCO)
Control File accompanying 834 monthly cutoff out (MCO)	Email containing summary counts of corresponding file	Monthly	MGC Saturday	Maximus	Health Plans (MCO)

Control File accompanying 834 monthly cutoff out (Prime)	Email containing summary counts of corresponding file	Monthly	1st Saturday in month on or after the 4th.	Maximus	Health Plans (Prime)
Provider Network					
Provider network file - in (MCO)	Provider network	As often as plan wishes to send, up to once/day	As often as plan wishes to send, up to once/day	Health Plans (MCO)	Maximus
Provider network file - in (Prime)	Provider network	As often as plan wishes to send, up to once/day	As often as plan wishes to send, up to once/day	Health Plans (Prime)	Maximus
Provider error-report out (MCO)	Errors/info encountered when processing corresponding inbound network file	This file is generated for every inbound network file received if there are errors/ issues.	1-2 days after the inbound file was received/processed.	Maximus	Health Plans (MCO)
Provider error-report out (Prime)	Errors/info encountered when processing corresponding inbound network file	This file is generated for every inbound network file received if there are errors/ issues.	1-2 days after the inbound file was received/processed.	Maximus	Health Plans (Prime)
Prime Risk Scores					
Risk scores out (Prime only)	A listing of all confirmed passive assignments made for the plan, with health risk scores and other data.	Monthly	2 days after passive assignment is confirmed; this is the latter half of the month.	Maximus	Health Plans (Prime)