SOUTH CAROLINA
Healthy Connections
MEDICAID

PROCESS and PROCEDURE MANUAL

For

MANAGED CARE ORGANIZATIONS

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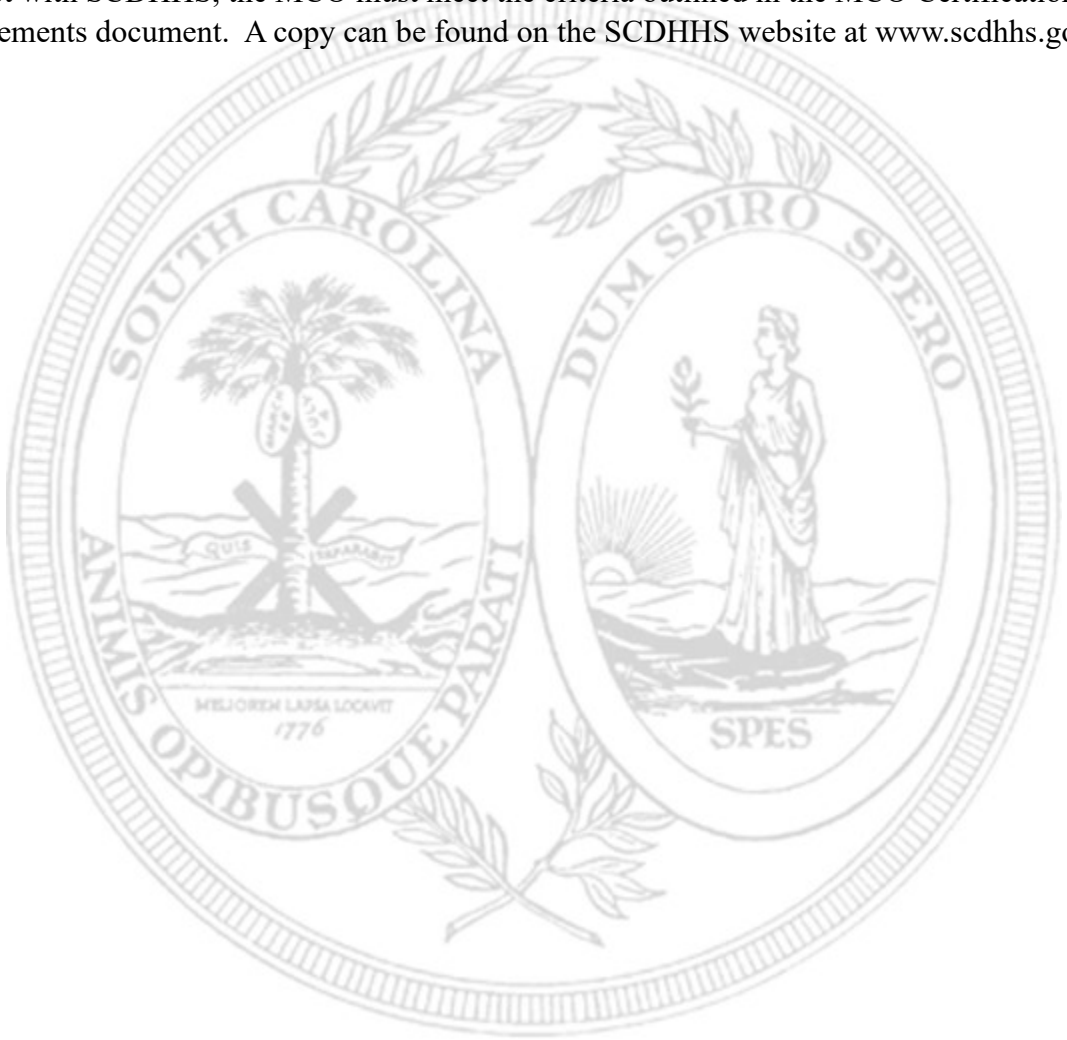
REQUIREMENTS FOR CERTIFICATION AS A MANAGED CARE ORGANIZATION (MCO)

A copy of the model MCO contract can be found on the SCDHHS website at www.scdhhs.gov. The model contract has been approved by the Centers for Medicare and Medicaid Services (CMS). The terms of the contract are established and are not negotiable.

SCDHHS will enter into a Risk-based contract with a qualified MCO to operate as a statewide domestic insurer in the State of South Carolina. To be considered qualified and enter into a contract with SCDHHS, the MCO must meet the criteria outlined in the MCO Certification Requirements document. A copy can be found on the SCDHHS website at www.scdhhs.gov.



Section 2: Contractor Administrative Requirements

2.7 Provider Enrollment and Credentialing

Section 2.7.2 through Section 2.7.2.5.3 Requirements for the Utilization of Nurse Practitioners (NPs) as Providers of Health Care Services

Medicaid MCOs may utilize Nurse Practitioners (NPs) to provide health care services under the following conditions:

1. Ensure NPs are able to perform the health care services allowed within the parameters of the SC Nurse Practice Act (State statute Section 40-33). MCOs must:
    a. Validate NP status
    b. Confirm the NPs ability to provide services by validating the written collaborative agreement.
    c. Verify there is a process in place to accommodate Medically Necessary hospital admissions.
2. Collaborating Physicians for practices staffed only by NPs must also be enrolled in the MCO's network and must have an active license. MCOs must:
    a. Authenticate the formal relationship between the NP and collaborating Physician
    b. Contract with any off-site collaborating Physician who is not already enrolled in the Plan's network.

If the collaborating Physician will not enroll, the NP-only practice cannot be enrolled into or, if already enrolled, cannot remain in the MCO's network.

Section 3: Member Eligibility and Enrollment

3.11 Member Disenrollment

Section 3.11.1 through Section 3.11.2.7

The same time frames that apply to Enrollment shall be used for changes in Enrollment and Disenrollment. If a Medicaid MCO Member's request to be Disenrolled or change MCO Plans is received and processed by SCDHHS by the internal cut-off date for the month, the change will be effective on the last Day of the month. If the Medicaid MCO Member's request is received after the internal cut-off date, the effective date of the change will be no later than the last Day of the month following the month the Disenrollment form is received. A Medicaid MCO Member’s Disenrollment is contingent upon their “lock-in” status.

Section 4: Core Benefits and Services

4.2 Specific Core Benefits and Service Requirements

4.2.17 through Section 4.2.17.1 Inpatient Hospital Services

The date of service will dictate the responsible MCO for any professional charges submitted on the CMS-1500 Claim Form. Similarly, if the Medicaid MCO Member is enrolled with Medicaid Fee for Service (FFS) on the date of admission, FFS Medicaid is responsible for facility charges for the duration of the inpatient stay to discharge and the MCO is responsible for professional charges submitted on the CMS-1500 Claim Form based on MCO Enrollment date and the service date on the professional Claim.

Section 4.2.22.2 through Section 4.2.22.2.6 Single Preferred Drug List

Additional requirements for utilization and management of each of the MCO's Comprehensive Drug List can be found in the matrix chart (Exhibit 4) below.

Exhibit 4- Managed Care Organization Comprehensive Drug List Requirements Matrix

Group	Classification	FMT Code	Criteria	Age/Dose/Qty (Dose Opt)
Managed *Drugs that are managed on the SCDHHS preferred drug list (PDL), as indicated by their NDC being included on the formulary management tool (FMT) file.*	Preferred	PFD	Plans must **not** impose any clinical or step-edit criteria. This does not include FDA labeling edits.	Edits will be established by plans and must be consistent with the FDA label/clinical guidelines and/or compendia if no guidelines are provided to the plans for that specific medication. If any of these parameters are included in the FFS criteria document, plans must follow the FFS criteria. In the future, FFS may include these data parameters on the FMT file, at which time the plans will be provided guidance.
	Preferred with Criteria	PFC	Plans will be expected to utilize the criteria provided for these drugs. This will ensure that the provisions of the supplemental rebate contracts are honored and that providers have a consistent experience across plans.	
	Non-Preferred	NPD	Plans must require a PA on these drugs and adopt the FFS PDL criteria (e.g., number of preferred drug failures, other access pathways). Again, this will ensure that the provisions of the supplemental rebate contracts are honored.	

Non-managed (products not currently on PDL) *Drugs that are **not** managed on the SCDHHS preferred drug list (PDL), as indicated by their NDC **not** being included on the FMT file.*	Non-managed	NDCs not on the FMT File	Plans may apply criteria in the same fashion currently in place. Plans must **not** publish any list of preferred drugs or collect supplemental rebates for these drugs. • This does not preclude plans from requiring the use of a generic instead of a brand when one is available, noting that all "brand-over-generic" situations will be managed and included on the FMT. DAW 1 situations where the prescriber mandates the brand name product, plans must require brand name product be dispensed and appropriately reimbursed. • It also does not preclude plans from adopting step criteria when they are indicated by the FDA label/clinical guidelines/or compendia.	Plans may continue to adopt and apply these edits.

*As additional drug classes or products become part of the FFS sPDL, those drugs will be added to the FMT file. The state will provide plans with these additions upon approval by the state's Pharmacy and Therapeutics (P&T) Committee and their effective date.
*The state reserves the right to revise or amend the table in part or in its entirety with sufficient notice.
* MCOs must follow rules delineated on PDL document.
*As with brands, the state may prefer specific generics and that information will be on the weekly FMT file and noted on PDL document.
*Last updated April 22, 2024

Tobacco Cessation Coverage

All FDA-approved tobacco cessation medications must be available without Member cost share or Prior Authorization. Medications subject to these requirements include bupropion for tobacco use (Zyban), Varenicline (Chantix), and nicotine replacement therapies in gum, lozenge, nasal spray, inhaler, and patch dosage forms. General Benefit edits related to Day supply limits should continue to be enforced. However, limits related to age, quantity, or number of quit attempts must not be more restrictive than the FDA labeling.

The following medically appropriate combination therapies must also be covered:

1. Long-term nicotine patch + other NRT product (gum or spray)
2. Nicotine patch + nicotine inhaler
3. Nicotine patch + Bupropion SR

Oral Buprenorphine

1. Buprenorphine/Naloxone
    a. To ensure access for members looking to initiate MAT, MCOs must allow at least a three-day initial supply for non-preferred buprenorphine/naloxone formulations.
2. Subcutaneous Buprenorphine
    a. Subcutaneous buprenorphine must be available without requirements for step therapy. Initial authorization must be for a period of at least six (6) months. Criteria for approval for continuation may include the requirements listed above.
3. Extended-Release Intramuscular Naltrexone
    a. Extended-release injectable naltrexone shall be provided without prior authorization. Step therapy parameters that require the use of oral naltrexone, methadone, or any formulations of buprenorphine or buprenorphine/naloxone combination therapies prior to receiving extended-release injectable naltrexone are not permitted except as otherwise indicated per package insert.

Section 4.2.25.4 SAMSHA Substance Abuse Risk Factors

Factors that place individuals at risk for developing substance use problems are recognized by Substance Abuse and Mental Health Administration (SAMSHA) and National Institute of Drug Abuse (NIDA), and there is extensive research available regarding bio-psychosocial behaviors/conditions that contribute to risk. These risk factors, in conjunction with actual substance use or abuse or an environment where substances are used or abused, indicate the need to treat the individual or family.

Risk factors should be identified and addressed throughout the assessment. Severity on ASAM dimensions should be reflected in documentation. The individual plan of care (IPOC) should be directly linked to the assessment findings and the risk factors should be addressed in the goals/objectives. Medicaid Members will be assessed by one of the thirty-three (33) county alcohol and drug abuse authorities and an Individual Plan of Care (IPOC) will be completed.

All MCO Members requiring Level I (discrete) or Level II.1 (Intensive Outpatient Program) services through DAODAS or its Subcontracted authorities will require the rendering Provider to fax a Prior Authorization (PA) request along with the IPOC and patient assessment. Should a PA be needed in support of a continuation of services, the rendering Provider must fax a Continued Stay Authorization form in addition to an updated IPOC when appropriate.

MCO Members requiring residential detoxification (Level III.2-D, Level III.7D), partial hospitalization/Day treatment (Level II.5), and/or residential treatment (Level III.5, Level III.7) through DAODAS or its Subcontracted authorities will require the rendering

Provider to call the MCO and request a PA for both the initial and continuation of services.

Service Level Agreements are in place with the MCOs to ensure a timely response from Provider requests for PA. MCOs must strive to provide a response for substance abuse services within five (5) Business Days to initial PA requests for Level I and Level II.5 services, MCO's maximum allowed response time for all PA requests is fourteen (14) calendar Days. MCOs are to respond to PA requests for detox, residential, partial hospitalization/Day treatment within twenty-four (24) hours, or no later than close of the following Business Day. Should a Member step down to Level I or Level II.1 services, the MCO is expected to provide a temporary PA to cover Level I and Level II.1 services for a period of five (5) Days, permitting the rendering Provider adequate time to fax documents as outlined above.

In addition to substance abuse services, the DAODAS commissions may also have the ability to provide non-substance abuse Behavioral Health Services. In an effort to strengthen Provider network adequacy, Health Plans are allowed and encouraged to utilize the commissions for more than just substance abuse related services.

Section 5: Care Coordination and Case Management

5.5 Continuity of Care Activities

Section 5.5.3 through Section 5.5.5.2

All MCOs are responsible for coordinating their Members care and providing necessary Case Management functions. Case management and Care Coordination functions continue even if the service is outside of the MCO's Core Benefit package outlined in Section 4 of the contract.

If it is discovered during Case Management and treatment that an MCO Member would benefit from:

1. Excluded Behavioral Health Services offered in FFS Medicaid.
2. Out of State organ transplantation services.
3. Out of State Non-Emergency medical transportation requested by the Member for services that the MCO's medical director deems Medically Necessary.

The MCO must provide the SCDHHS medical directors with the information listed below for SCDHHS to render a final decision on Medicaid FFS coverage for the services listed above:

All current physical Heath Records for the Member needing services not offered through the MCO's Core Benefit package.

All current Behavioral Health Records for the Member needing services not offered through the MCO's Core Benefit package.

Summary of the presenting issues that have led the MCO and its medical director to request services beyond the Core Benefit package. Conclusions and a recommendation to the SCDHHS medical directors regarding the Medical Necessity of the care being requested by the MCO's medical director. MCOs may contact their Managed Care Program liaisons at SCDHHS if they need assistance in contacting one of the SCDHHS medical directors.

Section 11: Program Integrity

11.1 General Requirements

Unless otherwise specified below, refer to Section 11.1 of the Contract for all requirements between MCO and SCDHHS.

The Department's Fraud hotline is organized within the Division of Program Integrity/SUR (PI), Department of Recipient Utilization (DRU) to accept tips and complaints from all sources concerning Provider and Member potential Fraud, Waste, and Abuse (FWA) that may be occurring in the SC Medicaid Program. Refer to Section 11.1.6 of this document for Member investigations of potential Fraud.

Section 11.1.6 Provider Fraud Referral

The MCO shall promptly perform a preliminary investigation of all complaints and allegations of suspected Fraud and Abuse against Providers or Members. A preliminary investigation may include interviews with Members, the provider or his staff, a desk or on-site review, and/or a records review. If the findings of a preliminary investigation give the MCO reason to believe that an incident of fraud has occurred by a Provider in the Medicaid program, or that a Credible Allegation of Fraud (CAF) exist, the MCO must promptly refer directly to PI using the Provider Fraud Referral Form. This form is located on the secure PI website (see the Managed Care Report Companion Guide). Examples of potential fraud indicators can be found under the Fraud and Abuse Indications of this Section. The Provider Fraud Referral Form must be accompanied by the MCO's complete investigative file, including but not limited to as applicable, preliminary investigation results, interviews, all records or documents collected, line by line review findings that substantiate any under or Overpayment, evidence supporting a Credible Allegation of Fraud, reviewer/investigative notes, Provider enrollment and Credentialing documents, related complaints, related data analysis, and any applicable repayment history.

If the preliminary investigation identifies suspected criminal activity outside the scope of program integrity, the MCO should report this directly to the Vulnerable Adults and Medicaid Fraud Unit (VAMPF) through VAMPF's Hotline and not on the PI Provider Notice Form.

If a Fraud referral has been made to VAMPF and VAMPF is documents the provider as stand-down on the VAMPF Active Case List on the secure PI website, the MCO:

1. May maintain routine business operations with the provider
2. Will cease all SIU activity, unless prior contact is made with VAMPF and special permission to proceed is granted in writing, including but not limited to:
    a. Initiating prepayment reviews based on the CAF referral
    b. Conducting post-payment reviews except as explicitly required under the terms of this contract,

i. However, such reviews shall be limited in scope to claims and data analysis
c. Notifying the provider of its post-payment review findings
d. Recouping overpayments affiliated with the CAF

3. Is not permitted to disclose to the Provider at any time during the course of the review that there is a suspicion of Fraud or that a referral has been made.
4. May resume all SIU activities after the VAMPF removes the provider from standdown on the VAMPF Active Cases standdown list.

Fraud and Abuse Indications

The MCO must conduct a preliminary investigation and report suspected Fraud and Abuse. The following are examples of indications of Fraud and Abuse:

1. For Providers/Subcontractors:
    a. Fraud:
        i. There is no documentation for the service.
        ii. There is an indication that documentation was altered, falsified, or manufactured after billing, or that signatures have been forged. For example, non-matching signatures, photocopied documentation, or documentation with "white-out" changes.
        iii. Unapproved marketing/recruitment of beneficiaries.
        iv. Unauthorized use of a provider's Medicaid ID, NPI, or other identification by another individual or entity.
        v. Billing for services not rendered. For example, billing for members that provider has never served, billing extra visits for a member, or billing for in- home services while the member was in an inpatient setting.
        vi. Intentional excessive utilization. For example, providers who are outliers compared to peers on claim volume, reimbursement, use of specific codes, use of specific diagnoses, or prescribing specific drugs, equipment, or supplies.
        vii. Material misrepresentation of information on the claim. For example, billing group therapy sessions as individual therapy; billing an incorrect diagnosis code to charge for a certain procedure.
        viii. Improbable or impossible billing scenarios. For example, billing for time-based services for more than 24 hours in a day, or more than 31 daily services in a month; billing individual services for more than one recipient for the same time and day.
        ix. Services provided or billed by a provider who has been excluded or terminated.
        x. Double-dipping (billing Medicaid and another funding source for the same service).
        xi. Intentional excessive billing for services that are not medically necessary.

xii. Upcoding.
xiii. Unexplainable significant spikes in claims volume or reimbursement.
xiv. Duplicate billing. For example, billing for the same service for the same recipient on the same day.
xv. Unbundling.
xvi. Drug diversion.
xvii. Billing for services outside the scope of practice.

b. Abuse:
i. Excessive utilization. For example, providers who are outliers compared to peers on claim volume, reimbursement, use of specific codes, use of specific diagnoses, or prescribing specific drugs, equipment, or supplies.
ii. Excessive billing for services that are not medically necessary.

2. For Members, the MCO must report Fraud and/or Abuse to the DRU when any of the following indications are present:
a. Suspicion that a Member submitted a false application to Medicaid.
b. Upon Discovery that a Member provided false or misleading information about family group, income, assets and/or resources, or any other information to gain eligibility for Benefits.
c. Indication of Medicaid card sharing with other individuals.
d. A Medicaid card was bought or sold.
e. Member engaged in selling of prescription drugs, medical supplies, or other Benefits.
f. Member obtained Medicaid Benefits that they were not entitled to through other fraudulent means.

MCO Responsibilities

For a suspicion of provider fraud, the MCO shall promptly provide the results of its preliminary investigation to PI, using the Provider Fraud Referral Form. For provider waste or abuse, the MCO shall provide the results of its investigation to PI using the Provider Waste & Abuse Referral Form. If a Provider was reported on the Waste and Abuse Form and is later suspected of fraud, the MCO must complete a new Provider Fraud Referral Form. All forms are located on the PI secure website (see the Managed Care Report Companion Guide). All forms must be uploaded and saved to the secure PI website, and then notification of the upload to PI.

The MCO shall cooperate fully in any further investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include, providing upon request, information and access to records, and access to interview MCO's employees and consultants, including but not limited to those with medical or pharmaceutical expertise in the administration of the Program, or in any matter related to an investigation.

To determine the scope of any risk, the MCO may be asked to perform its own review, or to screen a provider review conducted by the Department or its designees. When asked to perform their own review, PI will upload a Waste and Abuse Referral Form to the secure PI website. The MCO will be responsible for conducting their own review based on the PI referral. The only requirement of the MCO is if they open a case, it will be reported on the Quarter Report. However, when PI asks the MCO to screen a PI review, PI uploads a Vetting Form to the secure PI website with an X indicating "Provider Encounter Data Review" to include a "Date Due Back". In this instance, the screening performed by the MCO is to ensure they are not reviewing the provider, nor have they collected an overpayment for the identified claims. After the screening, PI will recover any identified overpayment from the provider. Refer to Section 11.4.4 of this manual.

Investigations of Members for potential Fraud are pursued entirely by the Department in conjunction with, and under specific contractual provisions between the Department and the Office of the South Carolina Attorney General, Medicaid Recipient Fraud Unit (MRFU). Complaints received on Members and determined valid by DRU staff are referred by PI to the MRFU.

SCDHHS Responsibilities

PI manages the organization, content, and structure of the secure PI website. The Department utilizes Microsoft's SharePoint as the current method of exchange to facilitate file transfers, information sharing and reporting between the MCO, the Department, VAMPF and external auditors. See Sections 11.1.16 through 11.1.16.2 of this document.

PI staff will assist in establishing a connection and passwords for MCO staff.

1. All Provider and Member referral forms are located on the secure PI website (see the Managed Care Report Companion Guide for the referral forms).
2. Any documentation, especially if voluminous or contains PHI, should be uploaded under the MCO's individual Shared Document folder on the secure PI website.
3. When requesting MCO staff access to the secure PI website, the MCO Compliance Officer must complete the External User SharePoint Access Request Form and email the completed form to PI. The request form can be found on the secure PI website dashboard.
4. When requested by PI staff, the Compliance Officer is responsible for the validation of MCO staff members who have access to the secure PI website; to include roster validation sent by PI. The Compliance Officer has 24 hours, or the next business day, whichever comes first, to notify PI staff when one of their staff members no longer requires access to the secure PI website.

PI staff will acknowledge receipt of all MCO referral forms within five Business Days by responding to the MCO's email indicating the referral form was received.

During initial intake of the MCO's Provider Fraud Referral Form, if it is determined the MCO did not meet the form requirements outlined in Section 11.1.6, or the form is incomplete, PI will

return the form to the MCO with required corrections and a return due date. If the MCO fails to return the corrected form, the PI may, at its discretion:

1. Conduct additional investigation and research into the matter.
2. Open its own Case; and/or
3. Return the referral to the MCO to pursue through its own administrative actions and/or additional investigation.

Once a completed Provider Fraud Referral Form is received, PI may schedule a meeting with the MCO, the VAMPF and PI to review the investigation and evidence to support a CAF; unless another MCO has referred a more egregious allegation, or a federal review is pending. This meeting may result in either the MCO or PI obtaining additional information to substantiate a CAF referral. Once PI determines a CAF exists, they will make a formal referral to the VAMPF and include the referring MCO's Referral Form. PI will also contact all MCOs to determine if other referrals should accompany this referral. Refer to Sections 11.1.6 and 11.1.10 of this document. PI will also be responsible for gathering information from all the MCOs and VAMPF regarding a Good Cause Exception (GCE) waiver and granting one if necessary.

1. If multiple MCOs submit Provider Fraud Referral Forms for the same provider, PI will select the most egregious referral and ask that MCO to present their case in the scheduled meeting. This will not exclude the others MCOs from being on standby to present their case.
2. In limited circumstances, the MCO Provider Fraud Referral may be referred directly to VAMPF without a meeting; such as if the provider is already under a federal review.

PI shall PI shall maintain lists on the secure PI website that communicates to the MCO all Provider exclusions, terminations for cause, providers on prepayment review and payment suspensions for credible allegations of Fraud.

Regardless of referral type to PI, the MCO has the discretion to put a Provider suspected of Fraud or Abuse on pre-payment review or take other preventive actions as necessary to prevent further loss of funds. For all other cites in Section 11.1.7, please refer to the contract for all requirements.

Section 11.1.10 through Section 11.1.10.2 Good Cause Exception

Per regulation 42 CFR §455.23, the MCO(s) must also suspend all Medicaid payments after the Department determines there is a CAF. The effective date of the suspension must be the effective date provided by the Department.

Section 11.1.11

Upon notification by the Department that a Provider has been placed on prepayment review by the Department, the MCO must also place the Provider on payment review to the same extent as the Department.

Notice of Prepayment

The MCO will complete placing the provider in their prepayment claims review program within five (5) Business Days of notification.

The MCO may maintain the Provider on their prepayment claims review program after PI closes the PI prepayment claims review case by issuing a new notice to the provider establishing the criteria for the MCO prepayment review.

SCDHHS Prepayment Claims Review Process

To ensure claims presented by a provider for payment meet the requirements of federal and State laws and regulations and claims payment criteria as defined by program specific policies and procedures, a provider may be required to undergo prepayment review. Providers under prepayment claims review may be required to submit paper claims with attached documentation for payment consideration. The PI prepayment review process is as follows:

1. Providers under prepayment claims review shall not be entitled to payment prior to claims review by designated SCDHHS staff. The designated SCDHHS staff will notify a provider in writing when PI/SURs determines the provider will be placed under prepayment claims review. The notice shall contain:
    a. An explanation of PI/SURs' decision to place the provider on prepayment claims review.
    b. A description of the review process.
    c. A description of the claims subject to prepayment claims review.
    d. A list of all supporting documentation the provider must submit with claims subject to prepayment review.
    e. A description of the process for submitting claims with supporting documentation.
    f. The standard of evaluation used to determine when a provider may be removed from prepayment claims review.
2. Prepayment claims review does not include a review of medical necessity for billed items and/or services.
3. All clean claims submitted for payment review shall be processed within thirty (30) calendar days of submission.
4. A provider shall remain subject to the prepayment review process until the provider achieves documented compliance with claims payment criteria. Claims payment criteria is defined as:

5. The provider achieves three (3) consecutive months with a minimum clean claim rate of eighty percent (80%) and the number of claims submitted each month is no less than fifty percent (50%) of the provider's average monthly submission of Medicaid claims for the three (3) month period prior to the provider's placement on prepayment review, or the last three (3) consecutive months' history of claims submitted.
6. If a provider fails to submit any claims following placement on prepayment review in any given month, the claims accuracy rating shall be zero percent (0%) for the month no claims were submitted.
7. If a provider fails to achieve eighty percent (80%) clean claims rate three consecutive months during the first six months of prepayment claims review. PI/SURs may:
    a. Continue the provider's enrollment in prepayment claims review for an additional six (6) months and re-evaluate the provider's clean claims rate at the conclusion of the twelve (12) month period; or
    b. Initiate provider termination for cause procedures for reason(s) outlined in the South Carolina Medicaid Provider Enrollment Manual located at www.http.//provider.scdhhs.gov and/or for reason(s) listed on the provider's Participation and Payment Agreement.
8. If a provider fails to achieve an 80% clean claims rate for three (3) consecutive months during the provider's additional six (6) months participation under prepayment claims review, PI/SURS will initiate provider termination for cause (TFC) procedures for reason(s) outlined in the South Carolina Medicaid Provider Enrollment Manual and/or for reason(s) listed on the provider's Participation and Payment Agreement.
9. If a provider under prepayment claims review voluntarily or involuntarily terminates from the state Medicaid program, the provider may be placed on prepayment claims review upon re-enrollment.
10. A provider under prepayment claims review may not withhold claims to avoid the claims review process. Any claims for services rendered during the period of prepayment review may still be subject to review prior to payment regardless of the date the claims are submitted for payment.

SCDHHS Compliance Monitoring

1. The designated DHHS staff will evaluate a provider's claims resolution activities to establish the provider's monthly clean claims rate after the provider's sixth (6th) month and twelfth (12th) month under prepayment claims review.
2. If a provider does not reach the 80% clean claims threshold for three (3) months, during the first six (6) months of prepayment claims review, the provider will continue on prepayment claims review for an additional six (6) months.
3. If after twelve (12) months the provider does not achieve the 80% clean claims rate for three (3) months of a six (6) month evaluation period, the designated DHHS staff will review the provider to:

a. Identify potential reason(s) to continue the provider on prepayment claims review, or
b. Identify potential reason(s) to terminate the provider for cause from the state Medicaid program (e.g., the provider failed to comply with the terms of the enrollment agreement, or the provider failed to comply with the terms of contract with the terms of contract with SCDHHS).

Section 11.1.16 through 11.1.16.2

If inconsistencies are continually noted, or failure to meet timely filing, PI may reject a report for non-compliance. After two rejected reports for non-compliance, the first corrective action will include a monthly attestation from the Compliance Officer or Program Integrity Coordinator for a 6-month period to ensure report accuracy, and up to or including liquidated damages.

Section 11.1.16 through Section 11.1.16.2 Report Types

SCDHHS Reporting of Payment Suspensions

Within the secure PI website, PI will document their action to suspend a Provider's payments based on a CAF on the Suspension list and upload copies of the notices/letters. PI staff will notify the MCO via email that the PI website has been updated.

Upon notification by PI the MCO shall effectuate this suspension of the Provider's Medicaid payments as soon as practicable. The MCO will document the actions they take against the Provider on the Suspension list on the secure PI website.

Section 11.1.17 Beneficiary Explanation of Medical Benefits (BEOMB)

The MCO must conduct a preliminary investigation to determine whether the services were received. If the MCO's investigation substantiates the allegations, they will submit the BEOMB as a referral to PI using the appropriate referral form.

PI may also conduct a special targeted BEOMB job where Members are surveyed to verify whether services from a Provider under PI review were received. PI shall retain any BEOMB's responses as part of its review regardless of the payment delivery system.

The MCO is also responsible for conducting an independent BEOMB program, under 42 CFR 438.608(a)(5), and should include the following procedures:

1. The MCO must have a method for selecting a statistically valid sample of members who received services.
2. The BEOMB letter must meet the minimum requirements as outlined in the contract.
3. The Member must be given a method to report any discrepancies; for example a self-addressed envelope, a hotline number, etc.

The Department's "Confidential Services" are defined as those sensitive services which the disclosure will violate a Beneficiary's right to privacy. The services below are excluded from monthly BEOMB statements mailed to beneficiaries for their verification of Medicaid services received.

1. Payment category = 10 (MAO Nursing Home)
2. Procedure code modifier = 0FP (Services Part of Family Planning Program)
3. Provider type = 04 (Private Mental Health), 10 (Mental Health and Rehab), 00 (Nursing Home), and 70 (Pharmacy)
4. Category of service = 13 (ICF Mental Retardation)
5. MMIS Provider control facility code (type ownership) = 011 (DDSN)
6. MMIS Provider control facility code = '010' (Dept Mental Health) and Provider Number <> '136078'

Confidential Diagnosis Codes as determined by the Confidential Indicator set by the MMIS Diagnosis Reference File. (The Diagnosis Code List will be maintained on the secure PI website.)

Under a targeted BEOMB run only, the MCO may inquire regarding confidential services for Members aged 15 and younger. This request must be identified on the Permission Request. The MCO must obtain specific and individual letter approval for each Permission request in which confidential services are identified.

Section 11.1.20 Annual Audit

PI will conduct an Annual Review of the MCO to ensure compliance with the managed care contract and policies and procedures, CFR requirements, State Regulations, SCDHHS Policy Manuals, and results of program integrity efforts. The MCO will be given advance notice of the review, to include a matrix of specific questions and requested documents that must be completed in advance of an on-site review. An on-site review will be conducted to review the matrix responses, gather any document request, additional questions, and a walk-thru of the MCO facility. After the review, PI will issue a final report to include findings, recommendations, best practices, and any necessary corrective action plans.

11.2 Compliance Plan Requirements

Section 11.2.10 through 11.2.11.1

The MCO will establish written Policies and Procedures to check federal and state databases to confirm the identity and determine the exclusion status of any Provider and/or Subcontractor that is not a South Carolina Medicaid Network Provider, and any person with an ownership or control interest, or an agent, or managing employee of the Provider and/or Subcontractor during enrollment and revalidation. These databases include the Social Security Administration's Death Master File, the List of Excluded

Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases the Department or the Secretary of Health and Human Services may prescribe (e.g., the South Carolina List of Excluded Providers). For Provider contracting or Credentialing, only the MCO is required to maintain written Procedures in their Compliance Plan that shall include requirements for checking federal and state Provider exclusion list. Only the MCO is granted access to the Department's internal list for checking TFC databases for these purposes.

When an MCO determines that a Provider/Subcontractor, or a Provider's/ Subcontractor's owner, agent, or managing employee, or an owner, agent, or managing employee of the MCO entity is excluded and/or terminated for cause from Medicare and/or Medicaid, the MCO shall immediately terminate the prohibited relationship. . The MCO must identify and recoup any erroneous Medicaid payments.

The MCO may retain a relationship with a Provider/Subcontractor after the MCO determines the Provider's/Subcontractor's owner, agent, or managing employee is excluded or terminated from Medicare and/or Medicaid for cause only after the Provider/Subcontractor terminates the prohibited relationship and any erroneous Medicaid payments made to the excluded/terminated individual or entity are reimbursed to the state Medicaid Program.

The MCO shall maintain documentation for audit purposes that show the MCO conducts routine checks of federal and state databases for all Providers that are not South Carolina Medicaid Network Providers to identify individuals and/or entities that are excluded or terminated from Medicare or Medicaid for cause.

11.4 Reviews and Investigations

Section 11.4.2

When conducting a post payment review for FWA activities, the MCO may utilize up to a three (3) year look back when defining their review period. The MCO will then select claims from within the review period based on the last. (See S.C. Code of Laws Title 38, Article 2, Section38-59-250, (B),(1) and (3)). With the review period defined, claims selected for review within this period are frozen and will not roll off as they age outside of the review period, nor will their dollars be subtracted from the identified overpayment. Depending on the preliminary findings, the MCO may expand their review period, as well as the number of claims to be reviewed.

For any review period that exceeds three years, the Compliance Officer must send a written request to the DHHS MCO PI Coordinator requesting permission from the Department and specifying the dates and details of the review. The MCO does not need permission to extend a review period once it ages past the three-year period.

Section 11.4.2.1 through 11.4.2.2

The MCO SIU investigative team shall conduct a minimum of twelve (12) program integrity related Provider on-site reviews per State Fiscal Year; unless under a Public Health Emergency by the federal government.

The SCDHHS Medicaid Provider Administrative and Billing Manual grants Program Integrity authority when requesting records as part of a Provider review; "The provider, therefore, must submit all requested records by the deadline given by Program Integrity." Program Integrity utilizes the following internal guidelines when requesting records.

1. For on-sites:
    a. The Provider must provide all records at the time of the on-site.
    b. If for any reason the Provider cannot furnish the records, they may be granted up to an additional forty-eight (48) hours.
    c. After the deadline given by Program Integrity, failure to submit records may result in recovery of payments made by Medicaid for all services for which records were not provided, up to and including Termination for Cause.
2. For desk audits:
    a. Depending on the Provider type and number of records requested, the Provider may be given up to two weeks to provide all records requested.
    b. After the deadline given by Program Integrity, failure to submit records may result in recovery of payments made by Medicaid for all services for which records were not provided, up to and including TFC.

The SCDHHS Medicaid Provider Administrative and Billing Manual extends this, and the above guidelines, to the MCO when requesting records as part of a Provider review. For any review in which the MCO is unable to obtain any of the requested records, the MCO should submit a Termination for Cause Referral Form (see the Managed Care Report Companion Guide).

The MCO should provide evidence of the following when requesting a TFC:

1. The records request letter to the Provider, and any supporting documentation of receipt by the Provider; such as via certified mail with return receipt signature through the United States Postal Service or telephone calls.
2. Documentation that the Provider failed to provide the records as a result of the records request letter.
3. Documentation of a follow-up onsite review, if conducted by the MCO, with the Provider to obtain the records as a result of the records request letter.
4. The onsite report detailing the investigative actions, including the Provider's failure to produce the records during the onsite.
5. Any other documentation to support the request to terminate.

Once the request has been received by PI, a formatted letter will be sent to the Provider requesting they contact the MCO within 15 business days to produce the requested records. If the provider fails to take the necessary action, PI will begin TFC proceedings.

Section 11.4.3.4 Vetting Form

In this instance, PI will review the MCO encounter claims and recover any identified overpayment from the MCO.

The MCO will be given up to thirty (30) Calendar Days to vet the review and/or investigative outcomes performed by the Department or its designees. Where the threat of harm to the Medicaid Program is considered significant by PI, the MCO must prioritize the vetting process and return the review with comments by the date assigned by either PI or its designee.

Section 11.4.4

The MCO may then receive a final report from the Department or its designee, which may include a directive to initiate Recoupment from the Provider. In accordance with Section 11.5.4 of the Contract, if the MCO receives such a request, the MCO will initiate action to recoup all Improper Payments within thirty (30) Calendar Days of notification.

If a Provider requests reconsideration or files a Dispute, the MCO must respond in accordance with the MCO's current Policies and Procedures. Furthermore, the MCO must initiate action within thirty (30) Calendar Days to recover the Overpayment from the Provider once the time frame for timely filing of the reconsideration has occurred, or if the applicable proceedings have run their course, whichever occurs later.

Upon determination that the MCO is unable to recover the Overpayment from the Provider, the reason must be communicated to the SCDHHS MCO PI Coordinator in writing.

Section 11.4.5 Fraud and Abuse

In the event of an established Provider Overpayment or underpayment, the MCO may be asked to adjust, void, or replace, as appropriate, each Encounter Claim to reflect the proper Claim adjudication. If a settlement agreement is reached, those Overpayments may be reported outside the Claims processing system in accordance with Section 11.6.1.2 of this guide. For instances in which the MCO is unable to, or fails to, adjust, void, or replace the proper claim adjudication, the MCO will be responsible for reporting year end Identified Overpayments from their Quarterly Report to the contracted Department Actuary for annual rate setting purposes.

11.5 Referral Coordination and Cooperation

Section 11.5.3.1

Attendance at all PI scheduled meetings is mandatory in person by both the MCO's Compliance Officer and the Program Integrity Coordinator; unless advance notice is given that the meeting may be attended virtually. In the event either the Compliance Officer or the Program Integrity Coordinator have a scheduling conflict, the Compliance Officer must notify the SCDHHS PI Coordinator. The MCO's Compliance Officer, Program Integrity Coordinator, and necessary investigative staff will meet at scheduled intervals with DHHS PI staff to discuss Cases and Fraud and Abuse referrals.

The Department and the MCO shall engage in meaningful collaboration efforts to establish effective, expedited, and secure exchange of data and information pertinent to reviews conducted by the MCO or the Department.

11.6 Overpayments, Recoveries, and Refunds

Section 11.6.2.2

The MCO shall remit to the Department with notification to the SCDHHS MCO PI Coordinator those funds offset as a result of this provision within thirty (30) Calendar Days of such offset. Such notice shall include the following information as applicable: Provider Name, NPI, CCN, Date of Service, Refund /Adjustment Date; Refund Reason, PI Case Number, MCO Reference Number, Check Number, Check Date, and Offset was requested by PI.

Section 11.6.2.3 through 11.6.2.3.7 Vetting Form

SCDHHS may analyze encounter claims to identify Overpayments made by the MCO to a Provider. When an overpayment is identified, SCDHHS will notify the MCO and the MCO must remit the amount of the Overpayment to SCDHHS. The MCO may then recover the Overpayment from the Provider.

If the MCO does not agree that an Overpayment has occurred or has a reason as to why the Overpayment was not acted upon, the MCO may dispute the Overpayment in writing, to the SCDHHS PI Director within 30 days. The dispute must state the reason the MCO believes an Overpayment did not occur or was not collected and may present additional information to support the MCO's position. Failure to meet contractual requirements or to meet state or federal requirements will not be an acceptable basis for dispute. SCDHHS will review the dispute and notify the MCO in writing whether the Overpayment will remain in place, be overturned, or be amended.

Upon receipt of the notice of Overpayment from SCDHHS, the MCO will have 90 days to send payment in the amount of the Overpayment to SCDHHS or ask that their account be offset. If the MCO has disputed the Overpayment the MCO will have 60 days from the receipt of a decision from SCDHHS to send payment. The MCO may pursue recovery from the Provider during this timeframe. The MCO may request an extension of the timeframe for payment by submitting a justification in writing to the PI Director prior to the deadline. Failure to remit an amount by the deadline will result in the Department withholding the amount from the MCO's capitation payment and imposing a $500.00 penalty per incident.

Section 11.6.3.1.2.2

The MCO may collect from a Provider as a result of its investigation due to FWA. However, if the Provider is listed on the VAMPF Active Case List, the MCO must obtain written permission from VAMPF prior to the initiation of any recovery.

11.10 Statewide Pharmacy Lock-in Program (SPLIP)

Section 11.10.1.1

All Members selected by the Department as candidates and uploaded on the secure PI website for the MCO by the Department, must be placed in the MCO's Lock-In Program.

Section 11.10.1.3

Only those Members identified during this review may be exempted from enrollment in the Lock-In Program. The MCO must document on the secure PI website the reason a particular Member was not locked in.

Section 11.10.2 through Section 11.10.2.1.4

Once approval is granted by PI, the MCO must then upload the letter template to their individual Member Material website in Share Point for the Division of Managed Care approval.

Section 11.10.2.1.3 Pharmacy Changes/Additions

There are times during a Member's lock in period that a second pharmacy (or even a third) may be warranted. These member requests must be evaluated and granted on a Case-by-Case basis, and must be initiated by the Member, or his or her doctor,

pharmacist, or immediate care giver. Some examples would include, but not be limited to needing a specialty drug, compound, or IV infusion therapy; people who travel from small towns to a medical center in a major city; being allergic to certain generics stocked at the Lock-In pharmacy; and going out of State for treatment with an extended recovery time, etc. In these Cases, the Member will be assigned a second lock in pharmacy and this pharmacy will be noted in the Case file located on the secure PI website. Of course, Pharmacy Members can change their lock-in pharmacies when they move to a new location, or their existing pharmacy closes, or the Member has a legitimate complaint with the current Pharmacy's services.

Section 11.10.2.3 Point of Sale

the MCO always has the option of removing the Member from the SPLIP if it is in the best interest of the Member's health. These will be on a Case-by-Case basis and should be granted by the Pharmacy Director. All notes pertaining to this removal must be documented in the Member's record on the secure PI website.

Section 11.10.3 through Section 11.10.3.1

The Member will be restricted or locked into one (or two if approved) pharmacy(ies) where all prescriptions paid by the Medicaid program will be filled for a period of twenty-four (24) consecutive months, two (2) years.

Section 11.10.3.3 – 11.10.3.4 Transfers

A transfer occurs when a Member enrolling in an MCO (receiving MCO) was previously enrolled under FFS or a different MCO Provider. It is the responsibility of the receiving MCO to continue the Member's enrollment in the SPLIPPI initiates this transfer through the live databank on the secure PI website, which includes dates, current pharmacy, and notes.

Section 11.10.3.5 Medication Overrides

There are four (4) conditions for which overrides for locked in Members are allowed:

1. The Member is out of town.
2. The Member's medication needed (strength, quantity, brans, and/or type) is not in stock at the lock-in pharmacy, or the pharmacy has gone out of business.
3. The selected pharmacy chooses not to serve the Member for cause.
4. The Member has moved and has not yet changed their lock-in pharmacy.

If the Lock-in Pharmacy verifies the medication is not in stock, an override of up to thirty (30) day supply will be approved with a coordinating pharmacy of the Member's choice that can supply the medication.

Section 11.10.3.6

PI staff will review SPLIP Member's eligibility monthly and update the data on the secure PI website for each MCO. If a Member changes Enrollment between MCOs or FFS, PI will update that data on the secure PI website indicating the new Provider of services. The Member's record will then be transferred to the new Provider and the Member's lock-in period will be continued.

Section 11.10.4 through Section 11.10.4.2 Appeals

The Member has appeal rights from the date of receipt of the Certified Notification Letter if they believe the Claims Medicaid paid in the six (6) month review period contains an error. Per the Notification Letter, the Member has the right to request a detailed claims report with the 6 months of claims data that ranked them for enrollment in the program. Because PI generates the report that identifies the six (6) months of Claims in question, and which may cross multiple MCO or FFS periods, the MCO must request this report from PI. (Refer to the contract, Section 9 Appeals). If the Member is enrolled in an MCO, they must first Appeal to the MCO. If this Appeal does not end in favor of the Member, a second Appeal to the Department may be requested. The MCO must keep Appeal records for audit purposes.

If the Member files an Appeal as a result of the Notification Letter, they will be granted a "stay of action" and removed from immediate placement into the SPLIP. It is recommended that prior to the hearing date, contact be made with the Member in an effort to resolve the issue; for example, selecting a new pharmacy, assigning a second pharmacy, or removal from the Program.

If the Member wins the first Appeal to the MCO, they will be removed from placement into the SPLIP, and the reason is documented on the secure PI website. If the Member is selected as a SPLIP candidate in the future, during the placement review process, the outcome of this Appeal will be taken into consideration.

If the Member loses the first Appeal to the MCO, the MCO must await the Hearing Officers Official Hearing Notification Outcome. The stay of action will remain for the Member's enrollment in the Program. The MCO will review Case status on the date by which a second Appeal must have been filed as established by the Hearing Officer.

If the Member files an Appeal to the Department, the stay of action remains until the Department's Hearing Officer renders his Official Hearing Notification Outcome.

If the Member wins a Departmental Appeal, they are removed from placement into the SPLIP, and the reason is documented on the secure PI website. If the Member is selected as a SPLIP candidate in the future, during the placement review process, the outcome of this Appeal will be taken into consideration.

If the Member loses a Departmental Appeal, the Member can either be placed in the SPLIP the following month or with the next Quarterly group. The Member will be given an updated Notification Letter WITHOUT Appeal rights.

If the Member does not file an Appeal to the Departmental and the time to file has expired, the Member can either be placed in the SPLIP the following month or with the next Quarterly group. The Member will be given an updated Initial Member Notification Letter WITHOUT Appeal rights. The MCO must document all Appeal information in the Member's Case file located on the secure PI website.

Section 11.10.5 Removal

After removal from the Program, the Member's future prescription Claims will be monitored. If the 20 criteria report identifies the Member based on a score, they will automatically be re-enrolled in the SPLIP.

11.11 CONTRACTOR Ownership and Control

Section 11.11.1 through Section 11.11.1.2.6

Subcontractors must report any changes of ownership and disclosure information at least thirty (30) calendar Days prior to the effective date of the change.

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

Additionally, the MCO must verify the Subcontractor's ownership disclosure information at least yearly based on the date of execution of the contract (agreement).

After verification by the MCO, if it is Discovered the Subcontractor/staff/owners/board members, or any of their Subcontractors/staff/owners/board members are on the Excluded Provider List, the MCO must immediately report the information to the Department and terminate the contract.

11.12 CONTRACTOR Providers and Employees – Exclusions, Debarment, and Terminations

Section 11.12.6

Termination for cause reasons shall be consistent with the TFC rationale listed in the CMS CPI-CMCS Informational Bulletin dated January 20, 2012, SUBJECT: Affordable Care Act Program Integrity Provisions – Guidance to States – Section 6501 – Termination of Provider Participation under Medicaid if Terminated under Medicare or other State Plan.

Section 11.12.7

When PI takes action to exclude or to terminate a Provider for cause, or to reinstate a Medicaid Provider's billing privileges, the Provider is informed of these actions through a letter sent via certified mail. "Exclusion" means that items or services furnished by a specific Provider who has defrauded or abused the Medicaid program will not be reimbursed under Medicaid or any Medicaid managed care program. Provider exclusions can be based on Fraud Convictions, loss of license, patient abuse, and other reasons. The MCO cannot contract with Providers that have been debarred, excluded, or terminated from Medicare and/or Medicaid for cause. The Department updates its website as needed with names of excluded individuals and entities.

PI provides copies of Provider exclusion and TFC notices to the MCO on the secure PI website. (See Section 11.1.16, SCDHHS Reporting of Exclusions, Terminations for Cause and Reinstatements, of this guide) The MCO is also required to complete routine checks of LEIE, SAM and the SC Excluded Provider List to determine if Providers, Subcontractors, owners, agents, or managing employees are excluded from participating in Medicare and/or Medicaid.

When PI reinstates an excluded Provider's eligibility to participate in the State Medicaid Program, it removes the Provider's name from the SC Excluded Provider's List located on the SCDHHS website. PI notifies the Provider in writing via certified mail. PI notifies the MCO of the Provider's reinstatement on the secure PI website and uploads a copy of the Provider's Reinstatement Notice. Reinstatement is not enrollment in the State Medicaid Program. To participate in the Medicaid Program, the Provider must submit an enrollment application as specified in the Provider Enrollment Manual found at https://www.scdhhs.gov/Provider.

"Termination" means the Department has taken an action to revoke a Provider's Medicaid billing privileges, the Provider has exhausted all applicable Dispute rights or the timeline for Dispute has expired, and there is no expectation on the part of the Provider or the Department that the revocation is temporary. Provider TFC is based on the Departments Provider Enrollment Policies found in the Provider Enrollment Manual

at https://www.scdhhs.gov/provider-type/provider-enrollment-manual. There are multiple reasons why the Department can terminate a Provider for cause.

PI determines if a Provider meets the conditions for TFC and ensures all Providers terminated for cause from the State Medicaid Program are reported to the Centers for Medicare and Medicaid Services (CMS) and to the DHHS Office of the Inspector General (OIG).

Section 12: Marketing Requirements

12.3 Marketing Plan Requirements

Social Media Activities

MCOs will consult with their legal team and appropriate parties regarding PHI protections, proactive messaging, and responses on social media.

Section 14: Encounter Data, Reporting and Submission Requirements

14.10 Data Validation

Section 14.10.8 through Section 14.10.8.3 EQI Reports

SCDHHS reserves the right to change the method of data completion verification upon reasonable advance notice to the MCO.

Section 15: Quality Management and Performance

Section 15.7.1 through Section 15.7.3.3 Provider Quality Incentive Programs

Patient Centered Medical Home (PCMH)

Retroactive requests and corrected files may only be backdated one quarter. SCDHHS will not pay MCOs for retroactive PCMH data outside of the prior quarter.

15.9 Alternative Payment Models (APM)

Section 15.9 through Section 15.9.5.2

For payments made to Providers as a pass-through from SCDHHS, such as the current PCMH arrangement, 50% of the value of the payments shall be counted toward the MCO's APM requirement.

APPENDIX 1 — Providers' Bill of Rights

Each healthcare Provider who contracts with SCDHHS or Subcontracts with the MCO to furnish services to the Medicaid Members shall be assured of the following rights:

A healthcare professional, acting within the lawful scope of practice, shall not be prohibited from advising or advocating on behalf of a Medicaid MCO Member who is his other patient, for the following:

The Medicaid MCO Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

Any information the Medicaid MCO Member needs to decide among all relevant treatment options.

The risks, benefits, and consequences of treatment or non-treatment

The Medicaid MCO Member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

To receive information on the Grievance, Appeal and Fair Hearing Procedures.

To have access to the MCO's Policies and Procedures covering the authorization of services.

To be notified of any decision by the MCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

To challenge, on behalf of the Medicaid MCO Members, the denial of coverage of, or payment for, medical assistance.

The MCO's Provider selection Policies and Procedures must not discriminate against particular Providers that serve High-Risk populations or specialize in conditions that require costly treatment.

To be free from discrimination for the participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certifications.