Managed Care Report Companion Guide

July 2025

Healthy Connections Medicaid

South Carolina Department of Health and Human Services

TABLE OF CONTENTS

INTRODUCTION

MCO REPORTS TO SCDHHS

This Reports Companion Guide is specifically designated for reporting formats that are either required by the Bureau of Managed Care or are sent to the MCO's in relation to a department initiative. Details regarding the reports can also be found in the contract. 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.

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 conventions.

If you have no data to report (ex: Key Personnel Changes), still submit the appropriate template and designate that you have 'nothing to report'. A full list of the reports that will be accepted with 'nothing to report' on the report template may be found in the *Attestation for Managed Care Reports* document.

Reports that are submitted directly to another program area's SharePoint site or to an FTP site do not need to be submitted to the Division of Managed Care/MCO SharePoint site. Specific submission locations within the Department may be found in the details provided within the description of the reports throughout this document.

If you have questions about required report submissions or timelines for submission, please contact your Managed Care Contract Monitor and they will assist you with your questions.

If you have questions or issues regarding the reports you receive on your FTP site, 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

MANAGED CARE REPORTS LIST

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
SECTION 1- General Provisions						
	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; within ninety (90) Days of the end of the state fiscal year	CONTRACTOR	DEPARTMENT
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 to CV/resume; monthly summary report is due the 15th 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	834 Report Layout	MCO receives these reports on a daily basis providing information on membership enrollment.	Daily	Daily	DEPARTMENT	CONTRACTOR
3.8	Eligibility Redeterminatio n	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
3.10	Health Plan Initiated Disenrollment Form	Required for requesting member disenrollment.	As Necessary	Ad Hoc, As Necessary	DEPARTMENT	CONTRACTOR
3.13	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 4- Core Benefits and Services						
4.2	Universal PA	Required of providers requesting prior authorization for (most) pharmaceuticals.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
4.2	Universal Synagis PA	Required of providers requesting Synagis.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
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

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
4.2	Drug Utilization Review (DUR)	Annual drug utilization review for all pharmacy claims.	Annually	Due May 31st of each year	CONTRACTOR	SCDHHS PHARMACY
4.2	Single Preferred Drug List Compliance Report	This report assists the state in monitoring the adherence rate to the sPDL.	Quarterly	Thirty (30) Calendar Days after the end of a quarter	CONTRACTOR	DEPARTMENT
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	Due within two (2) days of final service approval	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 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
4.3	Institution for Mental Disease (IMD)	Report provided to MCOs for members aged 21-64 with an IMD stay exceeding 15 days.	Annually	180 Days following the end of the fiscal year	DEPARTMENT	CONTRACTOR

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
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	Case Management Report	Report of members receiving case management services- to include Intensive Case Management- 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	PROVIDER
SECTION 6- Networks						
6.2	Network Adequacy Report	Adequacy report sent to the MCOs within ten (10) business day of receipt from 3rd party vendor.	Quarterly	60 days after the Provider Network Submission is due	DEPARTMENT	CONTRACTOR
6.3	Provider Network Submission	MCO report sent to SCDHHS reflecting MCOs entire provider network.	Quarterly	15th of the first month of the quarter	CONTRACTOR	DEPARTMENT
6.5	Non-Par Template	Submission of the MCO's utilization of non-participating providers.	Monthly and as requested by the Department	Fifteenth (15th) of each month	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
6.6	Annual Network Development Plan	A detailed description of the MCO's provider network development plan to ensure provider network adequacy.	Annually	Sept 1st of each year	CONTRACTOR	DEPARTMENT
SECTION 7- Payments						
7.2	Medical Loss Ratio (MLR)	Medical Loss Ratio report indicating the proportion of premium revenues spent on clinical services and quality improvement.	Annually	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 to complete 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
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	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

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
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
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
7.10	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
7.10	Annual Independent Audit Report	A report produced by independent auditors that is on a SFY basis and pertains only to Medicaid.	Annual	Due March 31 following the end of the prior state fiscal year	CONTRACTOR	DEPARTMENT
SECTION 8- Utilization Management						
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	CONTRACTOR	DEPARTMENT

				after the end of a fiscal year		
Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
8.5	Service Authorization Requirements by Benefit Type Report	A list of all services requiring authorization (e.g., prior, concurrent), categorized by benefit classification (Inpatient, Outpatient, Emergency Care, Prescription Drugs) and benefit type (MH/SUD or M/S).	Annually & Upon Material Change	Within ten (10) Business Days of any material change; Annually by deadline defined in Section 8.5.3	CONTRACTOR	DEPARTMENT
SECTION 9- Grievance and Appeal Procedures & Provider Disputes						
9.1	Grievance and Appeals Procedures & Provider Disputes	The MCOs written Beneficiary Grievance, Appeal and Provider Dispute Policies	Annually	Due July 1st	CONTRACTOR	DEPARTMENT
9.3	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
9.10	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						
10.10	TPL Casualty Cases	Any casualty cases that the MCO is aware are ongoing.	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
10.10	TPL COB Savings	TPL 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
10.10	TPL Cost Avoidance	TPL 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
10.10	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
10.10	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	The fifteenth (15th) Day of the following month	CONTRACTOR	DEPARTMENT
SECTION 11- Program Integrity						
11.1	Provider Fraud Referral Form	Form for reporting potential provider fraud and located on the PI SharePoint site.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Provider Waste, Abuse, and Tip Referral Form	Form for reporting potential provider waste and abuse and located on the PI SharePoint site.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
11.1	Member Waste, Abuse, and Tip Referral Form	Form for reporting potential member waste and abuse issues that can be found on the PI SharePoint site.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Targeted Beneficiary Explanation of Medicaid Benefits (BEOMB) Letter	BEOMB letter used for Members to verify if the listed services were received from the listed Provider(s) on the specified date(s). .	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Targeted Beneficiary Explanation of Medicaid Benefits (BEOMB) Permission Request Form	For the MCO to request permission to conduct a targeted BEOMB run.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Provider Terminations for Cause	SharePoint template for reporting provider terminations for cause and reinstatements.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Provider Exclusions	SharePoint template for reporting provider exclusions.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Provider Payment Suspensions	SharePoint template for reporting provider payment suspensions.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Provider Prepayment Reviews	SharePoint template for reporting provider prepayment reviews.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
11.1	Request for Good Cause Exception (GCE) to Provider Payment Suspension 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	DEPARTMENT	CONTRACTOR
11.1	MCO Fraud, Waste, and Abuse Quarterly Report	Quarterly reporting of fraud, waste, and abuse. This report should be submitted directly to the PI SharePoint site.	Quarterly	Within thirty (30) calendar days after the end of a quarter	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Overpayments Reporting	SharePoint template for reporting provider overpayment identification and recovery.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.1	Annual Strategic Plan	Annual Strategic Plan Matrix can be found at PI SharePoint site.	Annually	At a date as determined by the Department	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.2	Annual Compliance Plan	Annual Compliance Plan Matrix can be found at PI SharePoint site.	Annually	Within ninety (90) calendar days after execution of the MCO contract, and annually thereafter	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.4	Termination for Cause Referral Form	Form for the MCO to report referrals for terminating a provider for cause.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
11.4	Vetting Form	Form initiated by the Department and sent to the MCOs to vet identified claims.	As Necessary	Ad Hoc, As Necessary	DEPARTMENT	CONTRACTOR

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
11.6	Verification of Services Provided (VOSP) Letter and Notification Referral	Used for the verification of services provided by the rendering Provider.	As Necessary	Ad Hoc, As Necessary	DEPARTMENT	CONTRACTOR
11.10	Pharmacy Lock-In Program Letters/ Instructions	Letter templates and instructions to be used by the MCOs to notify members and pharmacies of a member's enrollment or removal from the program.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	MEDICAID MEMBERS/ ASSIGNED PHARMACY
11.12	Provider Termination/Denial for Cause Monthly Report	MCO Monthly reporting of providers terminated for cause that should be submitted directly to PI's SharePoint site.	Monthly	The fifteenth (15th) day of the following month	CONTRACTOR	SCDHHS PROGRAM INTEGRITY
SECTION 12- Material Review						
12.2	Marketing Materials	Copies of any marketing materials the MCO will be using related to Medicaid services.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
12.6	Marketing Activities Submission Log	Log MCOs use to notify DHHS of upcoming marketing activities.	As Necessary	Ad Hoc, As Necessary	CONTRACTOR	DEPARTMENT
12.8	Annual Marketing Plan	Schedule and details of events, initiatives, marketing materials, and incentives the plan intends to distribute for the next calendar year.	June 1	Annually	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 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

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
14.8	FQHC/RHC Encounter Reporting	Encounter claims data organized by date of service for all contracting FQHC & RHCs 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 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 (QAPIP)	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 1st for previous calendar year	CONTRACTOR	DEPARTMENT

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
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
15.6	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
15.7	Patient Centered Medical Homes (PCMH) Assignments	MCO's submission is monthly and utilized to reimburse those primary care practices that qualify for this incentive payment.	Monthly	The fifteenth (15th) Day of the following month	CONTRACTOR	Bureau of Managed Care
15.7	Patient Centered Medical Homes (PCMH) Payment Summary	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
15.7	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 Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
15.8	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 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 F- BabyNet						
Appendix F	BabyNet Members	Report of members receiving BabyNet Services.	Monthly	By the 1st Monday of every month	DEPARTMENT	CONTRACTOR
Appendix F	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 the contract for all 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 the Contract for all details. Whenever changes are required, upload to the Required Submissions library in SharePoint.

Section 2.6

Subcontractor Boilerplate

The electronic redline contract submission of the Subcontractor Boilerplate agreement must contain the following information:

- An electronic redline version of the Subcontract or boilerplate showing all requested language changes and deviations from the approved model.
- Headers, completed reimbursement page, completed information of Subcontract facility(ies) including locations, complete Subcontractor information including location(s), attachments or amendments, and the projected execution date of the Subcontract.
- Covered Programs (i.e., South Carolina Healthy Connections Medicaid)
- Footer information containing the original model Subcontract approval number and date.

Once the redlined Subcontract or boilerplate has been given tentative approval by SCDHHS, the footer information will be changed to a tracking number provided by SCDHHS. The MCO must submit a black line copy of the tentatively approved redlined Subcontract or boilerplate for final approval.

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 C* in the *Maximus Reports* chart.

Section 3.8

Redetermination Report

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

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. Both files are produced in the third (3rd) weekend of the month on Saturday and are available for the MCOs to retrieve on the following Monday.

Member Enrollment status may be tracked by the MCO using the following information provided by SCDHHS:

- Date of Enrollment is included in daily and monthly 834 files (RSP-ELIG-DATE) and monthly MLE files (date of Enrollment). A Member must complete the review form by the review date listed on the

Redetermination report sent to the MCOs to avoid Disenrollment. Review dates are no sooner than one (1) year after the date of Enrollment.

- Medicaid eligibility status can be checked at any point using the eligibility web portal.
- Monthly Redetermination files list Members who will need to re-Enroll within the next sixty (60) Days.
- Members who have been successfully re-Enrolled or Disenrolled are included in both daily and monthly 834 files.
- MCOs are not notified if review forms have been received and are in process. However, the Medicaid call center can identify whether a review form has been received.

Section 3.10

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 3.13

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

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

High Cost No Experience Drug Report

This report is utilized for requesting reimbursement of High Cost No Experience pharmaceuticals as defined in the Managed Care contract. To qualify for reimbursement by SCDHHS, use of the medication must be consistent with the FDA label and any generally accepted treatment guidelines. To validate this requirement, the MCO should submit any clinical notes or other relevant information from the prior authorization process with the report template submission.

Report submissions should be completed as necessary but no more frequently than monthly. MCOs must submit the template and associated documentation to their SharePoint site in the monthly submissions library.

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

SCDHHS will monitor the HCNE list on a quarterly basis and communicate updates to this list through this guide. MCOs may request SCDHHS review of coverage guidelines to ensure that approved cases will qualify for reimbursement. MCOs should submit those requests to pharmacy@scdhhs.gov. MCOs may also recommend drugs for inclusion in this program. Those requests, including any documentation and rationale that would support inclusion in this program, should also be submitted to pharmacy@scdhhs.gov. The following table (*Exhibit 2*) lists the pharmaceutical therapies approved for inclusion in the pharmacy risk mitigation program.

Exhibit 2- SCDHHS High Cost No Experience Drug List

South Carolina Department of Health and Human Services High Cost No Experience Drug List			
Drug Name	**FDA Approval Date**	**Program Inclusion Date**	**Program Removal Date**
Takhzyro	8/23/2018	7/1/2020	6/30/2021
Revcovi	10/5/2018	7/1/2020	6/30/2021
Gamifant	11/20/2018	7/1/2020	6/30/2021
Esperoct	2/19/2019	7/1/2020	6/30/2021
Zolgensma	5/24/2019	7/1/2020	6/30/2022
Vyondys 53	12/12/2019	7/1/2020	6/30/2022
Viltepso	8/12/2020	8/12/2020	6/30/2023
Zokinvy	11/20/2020	11/20/2020	6/30/2023
Oxlumo	11/23/2020	11/23/2020	6/30/2023
Danyelza	11/25/2020	11/25/2020	6/30/2023
Amondys 45	2/25/2021	2/25/2021	6/30/2023
Nulibry	2/26/2021	2/26/2021	6/30/2023
Ryplazim	6/4/2021	6/4/2021	6/30/2023
Nexviazyme	8/6/2021	8/6/2021	6/30/2024
Livmarli	9/29/2021	9/29/2021	6/30/2024
Rethymic	10/8/2021	10/8/2021	6/30/2024
Scemblix	10/29/2021	10/29/2021	6/30/2024
Vyvgart	12/17/2021	12/17/2021	6/30/2024
Recorlev	12/30/2021	12/30/2021	6/30/2024
SFY 2025 HCNE List			
Zynteglo	8/17/2022	8/17/2022	**
Xenpozyme	8/31/2022	8/31/2022	**
Skysona	9/16/2022	9/16/2022	**
Hemgenix	11/22/2022	11/22/2022	**
Lamzede	2/16/2023	2/16/2023	**
Daybue	3/10/2023	3/10/2023	**
Joenja	3/24/2023	3/24/2023	**
Vyjuvek	5/19/2023	5/19/2023	**
Elevidys	6/22/2023	6/22/2023	**
Roctavian	6/29/2023	6/29/2023	**
Sohonos	8/16/2023	8/16/2023	**
Veopoz	8/18/2023	8/18/2023	**
Pombiliti	9/28/2023	9/28/2023	**
Fabhalta	12/5/2023	12/5/2023	**
Casgevy	12/8/2023	12/8/2023	**
Lyfgenia	12/8/2023	12/8/2023	**
Beqvez	4/25/2024	4/25/2024	**
Ojemda	4/23/2024	5/9/2024*	**
Lenmeldy	3/18/2024	6/24/2024*	**
Tecelra	8/1/2024	8/23/2024*	**
Miplyffa	9/20/2024	9/20/2024	**
Aqneursa	9/24/2024	10/3/2024*	**

**Payment for Casgevy and Lyfgenia should be made separate and apart from the DRG payment for the corresponding hospital admission.*
** Program Inclusion Date represents date the manufacturer began participating in the Medicaid Drug Rebate Program*
*** Pharmaceutical treatments effective in the SFY 2025 HCNE program*

Single Preferred Drug List (sPDL) Compliance Report

MCOs must complete the Department's template for reporting the pharmacy products the MCO has provided to its Members for the previous quarter. The Department may, at its discretion, update the template to reflect a different set of market baskets that the Department wishes the MCOs to report on. The Department expects to deliver the reporting to each MCO approximately thirty days before the report due date, but on occasion may deviate from the schedule due to unforeseen circumstances. Regardless of when the report template is provided to the MCOs, the MCOs are still expected to complete and submit the report by the established due date. MCOs will submit the completed report through their SharePoint site, within the Quarterly Reports folder, under the applicable Fiscal Year and Fiscal Quarter folders.

The MCOs will use the Department's FMT file for the Department's Single Preferred Drug List. Additional definitions and utilization criteria for the MCO's Comprehensive Drug Lists may be found in *Exhibit 3*.

Exhibit 3- 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

Section 4.3

Additional Services Request Form

If an MCO would like to request to provide additional services beyond the core benefits to change and/or improve health outcomes among its Membership, then the MCO must submit all required information as it appears on the Additional Services Request Form to SCDHHS for review. The MCO will 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.

Approved/Denied forms will be uploaded by SCDHHS to the MCO's Shared Documents folder on SharePoint/Office 365. 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 (Implementation year)*

REQUIRED FIELDS FOR ADDITIONAL SERVICES REQUEST FORM	
Implementation Date	Enter the date the MCO intends to begin implementation of the changes to the additional service.
Additional Service Request Name	Name or title/subject matter of this additional service request.
Background and Rationale	Complete description of problem statement (if applicable) and reason for request, as well as rationale supporting the selection of this specific additional service. Why is it thought that the service will be successful or helpful?

Objectives	Statement of what the MCO is trying to accomplish with this additional service request. What exactly is being offered? Include details such as how many items are included, what is included, when the service is offered, where the service if offered, and how. Is there a vendor? What is the process for offering this service from start to finish?
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? What will be used to gather the data to support the effectiveness of this service?
Marketing Strategy for this service (Method, frequency etc.)	Define the marketing strategy, to include the exact methods and frequency used to market this service.
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 the completion of the measurement period, the MCO must provide post-intervention performance data, cost per service, and a yearly projection.
Subject Population/Comparator	The population that you are targeting for this intervention; please be specific. Examples include the following: age grouping/dates of enrollment/ diagnoses/ procedural codes.
Cost for service and yearly projection	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.
Procedure Code (required)	Enter the procedure code(s) for the service being provided.
Ineligible Criteria	Define reasons why someone may be removed or ineligible for the service, including, but not limited to, age or population-specific ineligibility criteria. *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; this can include data that shows the program was unsuccessful or had challenges.

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

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 on the Healthy Connections Choices website. An example of the chart may be found below in *Exhibit 4*.
A copy of the current list may be found at https://www.scchoices.com/Member/Step3PBECompare.aspx?frommenu=true

Exhibit 4- 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

Additional Services Evaluation Report

An Additional Service Evaluation Report is required to be submitted by the MCO quarterly. This report shall act as a review of all Additional Services the MCO offers to its Members and the effectiveness of those services.

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

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 in *Exhibit 5*.

Exhibit 5: 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 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 case management during the month, to include reporting of Intensive Case Management. The report template can be found at https://msp.scdhhs.gov/managedcare//site-page/excel-report-templates

Section 5.5

Universal Newborn PA

Providers need to complete this form in cases where a newborn is being seen out of network with an MCO. This form is available on the SCDHHS website at https://msp.scdhhs.gov/managedcare/site- page/reference-tools

Section 5.6

CMS-1500 Claim Form

To adhere to transition of care requirements as outline in the Managed Care Contract, the MCO that covers a Member on the Day of admission to a hospital is responsible for the facility charges associated with the entire stay (through discharge), even if the Member changes to another MCO or FFS during the hospital stay or if the Member switches eligibility categories at the end of a month.

The date of service will dictate the responsible MCO for any professional charges submitted on the CMS-1500 Claim Form. Similarly, if the Member is

enrolled with Medicaid 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 based on MCO Enrollment date and the service date on the professional Claim.

Example: An MCO (MCO1) Member is admitted to a hospital on August 20th and discharged on September 15th. On September 1, the Member changes to a new MCO (MCO2). MCO1 is responsible for all facility charges from admission to discharge and all Physician charges from August 20th to August 31st. MCO2 is not responsible for any facility charges but has responsibility for all Physician charges from September 1st to September 15th.

SECTION 6
NETWORKS

Section 6.2

Network Adequacy

A full list of the Network Adequacy Service Groups and their designated taxonomy descriptions can be found in *Appendix D* of this guide.

- Network Adequacy Chart- Service Groups Facilities Providers
- Network Adequacy Chart- Service Groups Ancillary and Professional
- Network Adequacy Chart- Service Groups Ancillary and Professional- Group Specialist

Section 6.3

Provider Network Submission

The purpose of this report is for the MCO to submit a complete listing of their provider directories which reflects providers who are contracted with the MCO to provide services for their members. The Provider Network Submission report must be submitted to SCDHHS quarterly and as requested by the Department. The template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Below are instructions, template layouts, data definitions, and codes required to be used in the Network Submission Report (*Exhibit 6*). *Exhibit 7* should be referenced when the MCO is completing their Network Submission Report. *Exhibit 8* should be used for the column "Accepting New Medicaid Patients". *Exhibit 9* should be used for the column "Languages Spoken by Provider or Staff".

Exhibit 6- Provider Network Submission Template

Plan specific information	Plan Name	Required by SCDHHS
	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 SCDHHS
	Taxonomy Code for Secondary Specialty	
	Group Name	
	Group Federal Employee ID Number	
	Provider License Number	
	Provider Email Address	
	Age Range Served	
Provider Hospital Affiliations (add more columns if needed)	Hospital Affiliation 1	
	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 SCDHHS
	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 SCDHHS

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 year ranges defined as follows: • Adult – Age Ranged served exclusively greater than 21 (Ex. 21-65, 65+, etc.) • Pediatric - Age Ranged served exclusively less than 21 (Ex. 0-21, 0-18, 10-20 etc.) • Both – Age Range served is inclusive of ages below and above 21 (Ex. 0-65, 18-65, All Ages etc.).
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 7* 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 8* 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 9* 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 7- 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 Hillcrest 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 8- 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	
Descriptor	Definition
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 9- Language Codes List

DHHS	Code	Language
S	SPA	Spanish
M	MDR	Mandarin
P	POR	Portuguese
V	VIE	Vietnamese
H	HIN	Hindi
K	KOR	Korean
C	CHI	Chinese
G	GUJ	Gujarati
R	RUS	Russian
A	ARA	Arabic
T	TUR	Turkish
B	POL	Polish
D	PER	Persian
F	FRE	French
I	ITA	Italian
J	JPN	Japanese
	AFR	Afrikaans
	BEN	Bengali

DHHS	Code	Language
L	LAO	Laotian
N	HMN	Hmung
O	Oth	Other
Q	GER	German
U	UKR	Ukrainian
W	ARM	Armenian
X	KHM	Khmer
Y	YID	Yiddish
Z	GRE	Greek
1	SMO	Samoan
2	HAT	Haitian
3	SGN	American Sign Language
4	TGL	Tagalog
5	NED	Nederland
6	EGY	Egyptian
	ALBA	Albanian
	AMH	Amharic
	BUL	Bulgarian

	CAM	Cambodian
	CRE	Creole
	CZEC	Czechoslovakian
	EST	Estonian
	FAN	Fante
	GUI	Gujarati
	HEB	Hebrew
	HUN	Hungarian
	IND	Indian
	KAN	Kannada
	LEB	Lebanese
	MAL	Malayalam
	MAR	Marathi
	NO	Norwegian
	PHIL	Filipino
	ROM	Romanian
	SIN	Sindhi
	SOMA	Somali
	SWE	Swedish
	TAM	Tamil
	THAI	Thai
	YOR	Yoruba

	CAN	Cantonese
	CRO	Croatian
	DUTC	Dutch
	ETH	Ethiopian
	FAR	Farsi
	HA	Hausa
	IBO	Ibo
	ICE	Iceland
	INDO	Indonesian
	LAT	Latino
	LIT	Lithuanian
	MALA	Malay
	NE	Nepali
	PASH	Pashto
	PUN	Punjabi
	SER	Serbian
	SLOV	Slovakian
	SWA	Swahili
	TAI	Taiwanese
	TEL	Telugu
	URDU	Urdu
	ZUL	Zulu

Section 6.5

Non-Participating Providers

This report must be submitted to SCDHHS monthly and as requested by the Department. Below are instructions and definitions on the submission of Non-Participating utilization to the Department.

MCOs should avoid creating additional Non-Par IDs and should not create a new Non-Par ID for each encounter. Overall, MCOs should limit Non-Par

Utilization only to necessary situations. For the date, the MCO should use the Paid Date of the Encounter.

Example: If service was rendered on March 30th, 2025 (Date of Service) but paid on April 20th, 2025 (Paid Date), the encounter should be reported for April 2025 (Month Year).

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

NON-PAR REPORT DATA DEFINITIONS AND FORMATTING		
COLUMN	Description	Format
YEAR	Calendar Year of file.	YYYY
MONTH	Month of record.	Full Month Name
NON-PAR ID	Distinct Non-Par ID of provider.	6- digit Alphanumeric
NPI	Distinct NPI of provider.	10-digit number
TAXONOMY	Distinct Taxonomy of provider.	10-digit Alphanumeric
COUNT OF CLAIMS	Count of final, paid Claims for distinct year and month.	Numeric only value
TOTAL $ AMOUNT	Total dollar amount paid for distinct year and month.	Numeric only value

SECTION 7
PAYMENTS

Section 7.2

Medical Loss Ratio Calculation

SCDHHS will provide instructions and templates for completing Medical Loss Ratio reports. The MCO will complete the report and return to the department by the department-designated due date.

Section 7.3

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 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 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 Bureau of Managed Care'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 six (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 six (6) when SCDHHS reviewed encounter records confirm the delivery. A copy of the Manual Maternity Kicker Schedule can be found below in *Exhibit 1*.

Exhibit 1- Manual Maternity Kicker Request Schedule

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

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 in *Exhibit 10*:

Exhibit 10: 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)

Rate Category		Month	Total	Previous Rates	Present Rates	Variance	Adjusted Capitated 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:						

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 in *Exhibit 11*.

Deceased Members Report

Each month the MCO will receive a report from SCDHHS indicating those Members that have passed away where the agency made a Capitation Payment for the deceased Member. This report will be individualized for each MCO operating within South Carolina and contain Member specific information. The information will be posted to the

MCO's SharePoint site in the monthly library. Capitation Payments for Members reflected on this report will be adjusted for the months the Member was deceased and a Capitation Payment was made by the Department.

Example: A Member is identified in July of 2014 as deceased. SCDHHS will recoup any premium payments made after July of 2014. The report posted monthly to each individual MCO monthly library in SharePoint will reflect each specific adjustment and time period.

Waiver and Hospice Members Report

There are instances where Capitation Payments might be made by the Department prospectively for members that are moved to one of the SCDHHS Home and Community Based Waivers or Hospice services. In these instances, the Department will seek to recoup the Capitation Payment that was made for months when the member was eligible for either program.

Each month the MCO will receive a report from SCDHHS indicating those Members that the MCO received a Capitated Payment for after that Member was moved from Managed Care. This report will be housed in the MCOs monthly library in SharePoint, individualized for each MCO operating within South Carolina and contains Member specific information.

Exhibit 11: 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 for 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 for 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.

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. The information will be posted to the MCO's SharePoint site in the monthly library and will contain Member specific information. SCDHHS will perform gross-level adjustments to the MCO for all members in this report to accurately pay premiums up to a year in arrears to ensure the Department correctly reimburses

the Health Plan at the dual Capitation Payment rate. An example of how this report will appear may be found in *Exhibit 12* below.

Example: *A Member is identified in July of 2014 that gained retroactive Medicare eligibility back to May of 2013. SCDHHS will adjust the MCO's premium payments back to August of 2013. The report posted monthly to each individual MCO monthly library in SharePoint will reflect each specific adjustment and time period. MCOs shall only initiate Provider claim Recoupment Procedures for adjusted premiums reflected in the monthly report. Providers of service(s) to these Members then may file Claims directly to Medicare to receive reimbursement.*

Exhibit 12: 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 7.4

State Directed Payments

SCDHHS has two hospital-related directed payment programs. These payment programs are not renewed automatically.

1. Health Access, Workforce, and Quality "HAWQ" program
2. Supplemental Teaching Physician Directed Payment Program

Following the end of a quarter, SCDHHS will calculate the funds due to each Hospital under both programs. SCDHHS will make lump sum payments to each MCO for the calculated amounts and corresponding reports will be delivered to each MCO specifically labeled for both the "HAWQ" program and the Teaching Physician directed payment program. SCDHHS will place the reports in a designated folder on the MCOs SharePoint site. SCDHHS will notify each MCO when the report is placed on the SharePoint site and will provide the file location and naming convention. This document must be uploaded to the appropriate folder in the MCOs SharePoint site.

SCDHHS expects to deliver the reporting to each MCO approximately sixty (60) days after the end of the quarter. SCDHHS intends to utilize the processing schedule reflected in the charts below (*Exhibit 13-15*), but on occasion may deviate from the schedule due to unforeseen circumstances.

Exhibit 13- FY 2024 Quarterly Hospital and Teaching Physician Directed Payment Schedule

(Prior FY Schedule) FY 2024 Quarterly Hospital and Teaching Physician Directed Payment Schedule		
Premium Date of Directed Payment Schedule	Quarterly Directed payment report Issued from SCDHHS	Expected Date of Payment to PROVIDER by MCO
July 1 – September 30 Premiums	November 30th	January 15th
July 1 – December 31 Premiums	February 28th	April 15th
July 1 – March 31 Premiums	May 31st	July 15th
July 1 – June 30 Premiums	January 31st	March 15th

Exhibit 14- FY 2025 Quarterly Teaching Physician Directed Payments Schedule

FY 2025 Quarterly Teaching Physician Directed Payment Schedule		
Directed Payment Period	Quarterly Directed payment report Issued from SCDHHS	Expected Date of Payment to PROVIDER by MCO
July 1 – September 30	November 30th	January 15th
July 1 – December 31	February 29th	April 1stth
July 1 – March 31	May 31st	July 1stth
July 1 – June 30	January 31st	March 1st

Exhibit 15- FY 2025 HAWQ Hospital Directed Payment Schedule

FY 2025 HAWQ Hospital Directed Payment Schedule		
Directed Payment Period	Quarterly Directed payment report Issued from SCDHHS (Estimated Date)	Expected Date of Payment to PROVIDER by MCO
Q1 Interim Payment	September 2023	Within 30 calendar days
Q2 Interim Payment	November 2023	Within 30 calendar days
Q3 Interim Payment	February 2024	Within 30 calendar days
Q4 Interim Payment	May 2024	Within 30 calendar days
Final Reconciliation based on actual SFY 2024	After March 2025	TBD

Independent Community Pharmacy Directed Payment Program

SCDHHS will place the reports in a designated folder on the MCOs SharePoint site. SCDHHS will notify each MCO when the report is placed on the SharePoint site and will provide the file location and naming convention. Payments will be made directly to the Independent Community Pharmacies indicated in the report. Upon issuance of the payment, the MCO will notify the Department by submitting a release of funds attestation. This document must be uploaded to the appropriate folder in the MCOs SharePoint site.

SCDHHS expects to deliver the reporting to each MCO approximately sixty (60) days after the end of the quarter. SCDHHS intends to utilize the processing schedule reflected in the chart below (*Exhibit 16*) but on occasion may deviate from the schedule due to unforeseen circumstances. SCDHHS will communicate any changes to the expected schedule.

Exhibit 16- FY 2025 Independent Community Pharmacy Directed Payment Schedule

FY 2025 Independent Community Pharmacy Directed Payment Schedule		
Directed Payment Period	Estimated Delivery of Quarterly Directed payment report Issued from SCDHHS	Expected Date of Payment to PROVIDER by MCO
July 1 – September 30	November 30th	December 30th
July 1 – December 31	February 29th	April 1st
July 1 – March 31	May 31st	July 1st
July 1 – June 30	October 31	December 1st

FQHC/RHC Wrap Payments

Encounter/Claims Detail Data are provided in a separate file in MS Excel file format (.xlsx). 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. *Exhibit 17* outlining the FQHC/RHC reporting schedule can be found below. The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Exhibit 17- FQHC/RHC Report Schedule

Initial Quarterly FQHC/RHC Report Schedule (Completed in Current Year)		
Service Dates of Quarterly Report	Through Paid Date	Report Due Date
January 1 – March 31	Claims Paid through May	May 31
April 1 – June 30	Claims Paid through August	August 31
July 1 – September 30	Claims Paid through November	November 30
October 1 – December 31	Claims Paid through February	February 28
Final Annual Quarter Repeat FQHC/RHC Report (Completed a Year after Initial Report was Submitted to SCDHHS)		
Service Dates of Final Quarterly Report	Through Paid Date	Report Due Date
January 1 – March 31 (Previous Year)	Claims Paid through May	May 31 (365 days from original submission)
April 1 – June 30	Claims Paid through August	August 31 (365 days from original submission)
July 1 – September 30	Claims Paid through November	November 30 (365 days from original submission)
October 1 – December 31	Claims Paid through February	February 28 (365 days from original submission)

RHC Reporting Requirements

The Medicaid MCO shall submit a report, quarterly, to its SharePoint quarterly library, of all paid Encounter/Claim data, by date of service, for all services rendered by RHCs for supplemental payment determination (wrap-around methodology).

This information shall be submitted in the required format no later than sixty (60) Days from the end of the quarter to the SCDHHS. This is an exception to the normal quarterly report requirement of submission within fifteen (15) Days of the end of a quarter.

The Department will complete an annual wrap-around reconciliation based on the RHC's fiscal year end. To complete this process, the following will be required:

1. Within one (1) year and sixty (60) Days of the MCO's quarterly RHC wrap-around report, all quarterly wrap-around files for the applicable quarter must be re-run (i.e., updated) to capture additional Encounter and payment data not available or processed when the initial quarterly RHC wrap-around report was originally submitted by the MCO.
2. Transmission requirements remain the same as the interim quarterly RHC wrap- around submissions. That is, the updated files must be uploaded to the MCO's SharePoint quarterly library, and the appropriate staff notified of it being uploaded to the site.

The CONTRACTOR Claims/Encounter data (i.e., Medicaid Recipient data, payment data, service/CPT codes) paid to each RHC by month of service to the Department for federally mandated reconciliation and auditing purposes. Encounter detail data and summary data shall be provided to SCDHHS as two (2) separate data spreadsheets in one Microsoft excel workbook. *Exhibit 18* reflects current wrap around methodology for Rural Health Clinics.

Exhibit 18- RHC Wrap Payment Methodology Effective October 1, 2023

RHC WRAP PAYMENT METHODOLOGY EFFECTIVE OCTOBER 1, 2023	
Allowed CPT Codes (1) (9)	Exclusions from RHC Encounter Rate (4) (8) (11)
Billable as a Medical Encounter:	IMAGING/RADIOLOGY
T1015 (11)	59025 (TC Modifier)
99202-99205	(70000-79999 TC only portion) Series-70% removed for Tech component (5)
99212-99215	92250/TC; 93325/TC; 93380/TC; 93970/TC
99242-99245	COVID TESTING
99381-99385	0202U; 86328; 86769; 87426; 87428; 87635; 87636;
99391-99395	87637; 87811; (U0001-U0002)
Add. Codes for Bi-Annual Exams (Adults):	IMMUNIZATION CODING/ADMINISTRATION (10)
99386; 99387; 99396; 99397	90375-90756; Q2035-Q2039
Podiatry:	COVID VACCINE & ADMINISTRATION (12)
Standard E&M codes - see above	90480; 91318-91322
Ophthalmology:	TOPICAL FLOURIDE VARNISH
92002, 92004, 92012, 92014	99188
Chiropractic:	ELECTROCARDIOGRAPHY
98940-98942	93005; 93017; 93041; 93225; 99217-99999*
In-Home, Domiciliary or Rest Home Services:	LONG-LASTING REVERSIBLE CONTRACEPTIVES
99341-99345; 99347-99350	11976; 11981; 58300; 58301; A4261; A4264; A4266-A4269; J1050; J7296; J7297, J7298, J7300; J7301; J7307
Skilled Nursing Facility Services:	LABORATORY SERVICES
99304-99310; 99315-99316;	80000-89999
Family Planning Service (separate visit):	AFTER HOURS SERVICES
99401-99402	99050; 99051
Postpartum Care:	BEHAVIORAL HEALTH SCREENING (SBIRT)
59430	H0002; H0004
Health Risk Assessment (Foster Care)	SUBSTANCE ABUSE SERVICES
96160, 96161	Q9991; Q9992; J2315
Billable as a Behavioral Health Encounter: (3)	TELEHEALTH ORIGINATING SITE

90791; 90792; 90832-90834; 90836-90839; 90847;	Q3014
96130; 96136	PHE LIMITED TELEHEALTH CODING (8)
T1015/HE	G2010; G2012; (99441-99443); (98966-98968); 92507
	97110; 97530; (99381-99385); (99391-99395)

* Any Hospital Based Service code in this range unless included in the "Allowed CPT Code" column.

(1) Allowed CPT Codes are those services considered as an eligible RHC encounter service. They are includable in the WRAP "count".

(2) When billing Medicaid Fee for Service claims the RHC must bill codes 99381-99385 or 99391-99395 to describe an EPSDT visit for a child, using a GT modifier if conducted via telehealth. All other E&M services must be represented using T1015 for the encounter.

(3) Behavioral Health Services codes that are considered as an eligible RHC encounter. A behavioral health code can be provided and billed on the same date of service as a medical service. Both services/encounters will be included in the WRAP settlement.

(4) Excludable procedure codes billed under MCO arrangements are not includable in the WRAP payment calculations and thus are carved out and reimbursed separately outside of the RHC encounter rate. For any procedure code billed outside of those identified under sections (1), (2), and (3), payment of these codes is included in the RHC encounter service rate and thus should not be separately reimbursed.

(5) The professional component of the 70000 series procedure codes is included in the RHC encounter servi e rate and thus should not be separately reimbursed.

(6) Group services should never be billed using the encounter rate. A billable encounter is a face-to-face, one-on-one service with a physician or mid-level practitioner. Note: RHCs are allowed to separately bill obesity services Under their group provider ID not their assigned Rural Health Clinic number. Please see the Physicians manual for additional information.

(7) Procedure codes will be reviewed annually to determine if updates are required in either billable encounter codes or excludable services.

(8) Note time limited/temporary telehealth coverage benefits per Medicaid Bulletins (MB) dated March 19, 2020 (MB# 20-004), March 23, 2020 (MB# 20-005), and March 25, 2020 (MB# 20-007), as additional Bill Above services.

(9) Time-limited/temporary telehealth coverage benefits include reimbursement of encounter visits not done via an in-person visit at the enhanced primary care rate.

(10) Adult reimbursement only, VFC reimburses for vaccines for children. Child reimbursement is limited to vaccine administration only.

(11) Note: RHC's are allowed to separately bill for obesity services under their group provider ID not their assigned Rural Health Clinic number. Please see Physicians manual for additional information.

(12) Vaccine and Vaccine Administration codes are effective as of 9/11/2023

Encounter Submission of FQHC Data

SCDHHS will capture Encounters with zero-line payments. If the MCO Encounter submission includes all applicable coding with no payment or with the FFS payment for codes reflected in *Exhibit 19* as excluded from the FQHC encounter rate, the department will be able to accept and process the Encounter.

MCOs may submit the full Encounter payment to SCDHHS through routine MCO Encounter submission, provided the submitted Encounter does not have a line paid amount that is negative.

FQHC Reporting Requirements

The MCO shall submit a report, quarterly, to its SharePoint quarterly library, of all paid Encounter/Claim data, by date of service, for all services rendered by FQHCs. SCDHHS will use this data to review and audit prospective payments to confirm the entire encounter rate was paid to all participating FQHCs.

This information shall be submitted in the required format sixty (60) days after the end of the quarter to the SCDHHS. This is an exception to the normal quarterly report requirement of submission within fifteen (15) Days of the end of a quarter.

The Department will complete an annual review based on the FQHC's fiscal year end. To complete this process, the following will be required:

1. Within one (1) year and sixty (60) Days of the FQHC's quarterly report, all quarterly files for the applicable quarter must be re-run (i.e., updated) to capture additional Encounter and Claims data not available when the initial quarterly FQHC report was originally submitted by the MCO.
2. Transmission requirements remain the same as the quarterly submissions. That is, the updated files must be uploaded to the MCO's SharePoint quarterly library, and the appropriate staff notified of it being uploaded to the site.

The CONTRACTOR shall submit the name of each FQHC and detailed Medicaid Claims/Encounter data (i.e., Medicaid Recipient data, payment data, service/CPT codes) paid to each FQHC by month of service to the Department for review and auditing purposes. Encounter detail data and summary data shall be provided to SCDHHS as two separate data spreadsheets in one Microsoft Excel workbook.

MCOs should only pay for codes that are reflected in the reimbursement methodology chart reflected in the table (*Exhibit 19*) below.

Exhibit 19- FQHC Wrap Payment Methodology Effective October 1, 2023

FQHC WRAP PAYMENT METHODOLOGY EFFECTIVE OCTOBER 1, 2023	
Allowed CPT Codes (1) (9)	Exclusions from FQHC Encounter Rate (3) (8)
Billable as a Medical Encounter:	59025 (TC Modifier)
T1015	IMAGING/RADIOLOGY
99202-99205	(70000-79999 TC only portion) Series-70% removed for Tech component (4)
99212-99215	92250/TC; 93325/TC; 93880/TC; 93970/TC
99242-99245	COVID TESTING
99381-99385	0202U; 86328; 86769; 87426; 87428; 87635; 87636;
99391-99395	87637; 87811; (U0001-U0002)
Add. Codes for Bi-Annual Exams (Adults):	IMMUNIZATION CODING/ADMINISTRATION (10)
99386; 99387; 99396; 99397	90375-90756
Podiatry:	Q2035-Q2039
Standard E&M codes - see above	COVID VACCINE & ADMINISTRATION (11)
Ophthalmology:	(90480) (91318-91322)
92002, 92004, 92012, 92014	VISION SERVICES
Chiropractic:	92340
98940-98942	ELECTROCARDIOGRAPHY
In-Home, Domiciliary or Rest Home Services:	93005; 93017; 93041; 93225; 99217-99999*
99341-99345; 99347-99350	LONG LASTING REVERSIBLE CONTRACEPTIVES
Skilled Nursing Facility Services:	A4261; A4264; A4266-A4269; J1050; J7296; J7297, J7298;
99304-99310; 99315-99316;	J7300; J7301; J7307
Family Planning Service (separate visit):	DRUG TESTING
99401-99402	80305; 80307; G0480
Postpartum Care:	SUBSTANCE ABUSE SERVICES
59430	Q9991; Q9992; J2315
Health Risk Assessment (Foster Care)	TELEHEALTH ORIGINATING SITE
96160, 96161	Q3014

MNT/Nutritional Counseling/Obesity Initiative: (5)	AFTER HOURS SERVICES
97802-97803	99050; 99051
Billable as a Behavioral Health Encounter: (2)	PHE LIMITED TELEHEALTH CODING (8)
90791; 90792; 90832-90834; 90836-90839; 90847;	G2010; G2012; (99441-99443); (98966-98968); 92507
96130; 96136; T1015/HE	97110; 97530; (99381-99385); (99391-99395)
Fluoride Varnish:	
99188	

*Any Hospital Based Service code in this range unless included in the "Allowed CPT Code" column.
(1) Allowed CPT Codes are those services considered as an eligible FQHC encounter service. They are includable in the WRAP "count".
(2) Behavioral Health Services codes that are considered as an eligible FQHC encounter. A behavioral health code can be provided and billed on the same date of service as a medical service. Both services/encounters will be included in the WRAP settlement.
(3) Excludable procedure codes billed under MCO arrangements are not includable in the WRAP payment calculations and thus are carved out and reimbursed separately outside of the FQHC encounter rate. For any procedure code billed outside of those identified under sections (1), (2), and (3), payment of these codes is included in the FQHC encounter service rate and thus should not be separately reimbursed.
(4) The professional component of the 70000 series procedure codes is included in the FQHC encounter service rate and thus should not be separately reimbursed.
(5) Current policy allows dietitian services as incident to a physician or mid-level service. That is, the beneficiary is seen by the provider (physician or mid-level) and dietitian on the same day, one encounter can be billed for the services received that day. Dietitian services cannot be billed independently from the services of the physician or mid-level.
(6) Group services should never be billed using the encounter rate. A billable encounter is a face-to-face, one-on-one service with a physician or mid-level practitioner.
(7) Procedure codes will be reviewed annually to determine if updates are required in either billable encounter codes or excludable services.
Note time limited/temporary telehealth coverage benefits per Medicaid Bulletins (MB) dated March 19, 2020 (MB# 20-004), March 23, 2020 (MB# 20-005), and March 25, 2020 (MB# 20-007), as additional Bill Above services.
(8) Time limited/temporary telehealth coverage benefits include reimbursement of encounter visits not done via an in person visit at the enhanced primary care rate.
(9) Adult reimbursement only, VFC reimburses for vaccines for children. Child reimbursement is limited to vaccine administration only.
Vaccine and Vaccine Administration codes are effective as of 9/11/2023

FQHC/RHC Summary Annual Reconciliation

This report will be uploaded 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 7.10

Annual Audited Financial Statement

The MCO must submit the annual financial report to its Annual Library on SharePoint by 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 (SCDOI) and should comply with the documents and format listed in *Appendix A*.

Section 7.10

Annual Independent Audit Report

The separate annual independent audit report is due March 31 following the end of the prior state fiscal year. The first year of required comparison of MLR data to the audit report relates to the preliminary MLR data for contract year July 1, 2023 – June 30, 2024. SCDHHS's delegated entity will modify the MLR reporting template to include the comparison. The comparison is required for the SFY 2024 preliminary MLR template and every year thereafter.

SECTION 8
UTILIZATION MANAGEMENT

Section 8.3

Service Authorization Report

On a Quarterly and Annual basis, MCOs will submit the Service Authorization Report to the SCDHHS SharePoint site. A copy of the Service Authorization Report template can be found at https://www.scdhhs.gov/providers/managed-care/managed-care-organizations-mco/managed-care-resources

SECTION 9
GRIEVANCE AND APPEAL PROCEDURES & PROVIDER DISPUTES

Section 9.1

Grievance and Appeals Procedures & Provider Disputes

The MCO must upload their written Beneficiary Grievance, Appeal and Provider Dispute Policies annually to its SharePoint Required Submission library. The MCO must upload any subsequent changes and/or revisions to its Grievance and Appeal Policy and Procedures to its SharePoint Required Submission library for approval prior to implementation of the Policy.

Section 9.3

Member Grievance and Appeal Log

This report is collected monthly and reported quarterly to SCDHHS. At a minimum, the report shall include the following elements: (1) Medicaid ID and name of the covered individual Medicaid Managed Care (2) Age of the individual (3) Appeal or Grievance type (4) The date received (5) The date of reviews and dispositions (6) Disposition results and status. (7) Disposition dates (8) Extension dates and decisions (9) Originating sources of the Grievance or Appeal. The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

Section 9.10

Provider Dispute Log

MCOs must provide SCDHHS on a quarterly basis written summaries of the Provider Disputes which occurred during each month of the reporting period to include:

- Nature of the dispute
- Date of the filing
- Resolutions and any resulting corrective action as a result of the complaint

These reports must be uploaded to the MCO's SharePoint quarterly library. The report template can be found at https://msp.scdhhs.gov/managedcare/site-page/excel-report-templates

SECTION 10
THIRD PARTY LIABILITY

Section 10.10

Third Party Liability Reports (TPL)

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

TPL Verification

This report consists of all MCO Members that have been identified as having TPL coverage that SCDHHS has not identified as having TPL coverage. The report will be uploaded to the SCDHHS FTP site on a monthly basis.

TPL Cost Avoidance

TPL refers to other health insurance, not Medicare. Do not include Medicare provider file encounters in this report. This report consists of all Claims during the month that have been identified as having Third Party coverage leading to cost avoidance by the MCO. This report must be broken into professional, institutional, and pharmaceutical Claim types.

The report will be uploaded to the MCO's SharePoint monthly library and will contain the following data elements: Medicaid Member ID, first name, last name, beginning date of service, ending date of service, Claim paid date, paid Provider NPI, submitted charges, paid amount, TPL amount declared on Claim, and amount cost avoided.

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".

TPL Coordination of Benefits (COB) Savings

TPL refers to other health insurance, not Medicare. Do not include Medicare encounters in this report. This report consists of all Claims during the month that have been identified as having Third Party coverage leading to coordination of Benefits savings for the MCO. The coordination of Benefits savings is defined as the amount saved because primary health insurance paid on the Claim. This report must be broken into professional, institutional, and pharmaceutical Claim types.

The report will be uploaded to the MCO's SharePoint monthly library and will contain the following data elements: Medicaid Member ID, first name, last name, beginning date of service, ending date of service, Claim paid date, paid Provider NPI, submitted charge, practice specialty description, primary health insurance payment, primary health insurance carrier code and Claim paid amount.

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".

TPL Recoveries

TPL refers to other health insurance, not Medicare. Do not include Medicare encounters in this report. This report consists of all Claims during the month that have been identified as having Third Party coverage leading to recoveries by the MCO. This report must be broken into professional, institutional Claim types and pharmacy Claim types. The report will be uploaded to the MCO's SharePoint monthly library and will contain the following data elements for each Claim type.

1. Professional Claims: Claim paid date, Claim control number, pay to Provider tax id, NPI, name and address, rendering Provider NPI and name, Member date of birth, Member name, beginning and ending dates of service, place of service, procedure code and modifier, procedure code description, units, diagnosis code(s), carrier code, carrier number, policy holder, policy number, submitted charge, paid amount, amount recovered, denial reason or no response, Provider carrier last date billed, and one hundred and eighty (180) Days from Claim paid Indicator (Y/N)
2. Institutional Claims: Claim paid date, Claim control number, pay to Provider tax id, NPI, name and address, attending Provider NPI and name, Member date of birth, Member name, beginning and ending dates of service, place of service, DRG code, bill type, principal diagnosis code, carrier code, carrier number, policy holder, policy number, submitted charge, paid amount, amount recovered, denial reason or no response, Provider carrier last date

billed, and one hundred and eighty (180) Days from Claim paid Indicator (Y/N)

3. Pharmaceutical Claims: Claim paid date, Claim control number, pay to Provider tax id, NPI, name and address, prescribing Provider NPI and name, Member date of birth, Member name, dispense date, NDC number, prescription number, drug name and description, quantity, Days supply, refill number, carrier code, carrier number, policy holder, policy number, submitted charge, paid amount, amount recovered, denial reason or no response, Provider carrier last date billed, and one hundred and eighty (180) Days from Claim paid Indicator (Y/N)

TPL Casualty Cases

This report consists of all Claims during the month that have been identified as the responsibility of a Third-Party payer and the MCO has paid the Claims. This report must be broken into open Cases, closed Cases and the number of Case alerts received (ex. questionnaires, attorney letters, Provider letters, insurance letters and the number of those Case leads that resulted in an open or closed Case).

The report will be uploaded to the MCO's SharePoint monthly library and will contain the following data elements:

1. Open Cases: Medicaid Member ID, first name, last name, date of injury, primary injury (diagnosis code), name of liable party, lien amount, date of lien notice sent, name of attorney/insurance company, Carrier Claim #, Case status, settlement amount, recovered amount (if $0 indicate $0 in field), dated closed, and three hundred and sixty five (365) Days from Claim paid Indicator (Y/N)
2. Closed Cases: Medicaid Member ID, first name, last name, reason for close, recovered amount and date closed and three hundred and sixty five (365) Days from Claim paid Indicator (Y/N).

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

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.

SECTION 11
PROGRAM INTEGRITY

Section 11.1

Provider Fraud Referral Form

When the MCO suspects and/or identifies potential provider fraud, they shall complete this form as thoroughly as possible. The completed form and supporting documentation shall be uploaded to the MCO's SharePoint site, in the Shared Documents Library, in the "Referral from TO DHHS PI" folder. Once the form is uploaded, send an email to omco@scdhhs.gov to notify Program Integrity (PI) of the upload. The form instructions and template can be found at the PI SharePoint site in the MC Health Plan Program Integrity – Forms and Letters Document Library or through the following link at MC Health Plan Program Integrity - Forms and Letters.

Provider Waste, Abuse and Tip Referral Form

When the MCO suspects and/or identifies potential provider waste and/or abuse, they shall complete this form as thoroughly as possible. The completed form and supporting documentation shall be uploaded to the MCO SharePoint site, in the Shared Documents Library, in the "Referral Form TO DHHS PI" folder. Once the form is uploaded, send an email to omco@scdhhs.gov to notify Program Integrity (PI) of the upload. The form instructions and template can be found at the PI SharePoint site in the MC Health Plan Program Integrity – Forms and Letters Document Library or through the following link at MC Health Plan Program Integrity - Forms and Letters.

Member Waste, Abuse and Tip Referral Form

When the MCO suspects and/or identifies potential member waste and/or abuse, they shall complete this form as thoroughly as possible. The completed form and supporting documentation shall be uploaded to the MCO's SharePoint Site, in the Shared Documents Library, in the "Referral Form TO DHHS PI" folder. Once the form is uploaded, send an email to omco@scdhhs.gov to notify Program Integrity (PI) of the upload. The form instructions and template can be found at the PI SharePoint site in the MC Health Plan Program Integrity – Forms and Letters Document Library or through the following link at MC Health Plan Program Integrity - Forms and Letters.

MCO Fraud, Waste, and Abuse Quarterly Report

The Quarterly Report is based on the State Fiscal Year beginning July 1 and ending June 30. The report is due no later than thirty (30) Calendar Days after the end of each quarter (Qtr 1, Oct 30; Qtr 2, Jan 30; Qtr 3, April 30; Qtr 4, July 30); and uploaded to the appropriate folder within the secure PI website.
The Quarterly Report will document activity during the quarter's three-month period (Qtr 1, July, Aug, Sept; Qtr 2, Oct, Nov, Dec, Qtr 3, Jan, Feb, Mar, Qtr 4, Apr, May, June) and will document outcomes and results of the MCO's Program Integrity efforts. This will include total overpayment amounts identified and recovered, active case data, Provider and Member referral activity, sanction activity, and Provider education. The completed report shall be uploaded to the MCO's SharePoint site, in the "Reports" section, in the "Quarterly Reports" folder, in the applicable year's folder.

Overpayments Reporting

Within the secure PI website, the MCO will document the identification and/or recovery of provider overpayments within 30 Calendar Days of each action taken.

The MCO shall report:
(1) The initial overpayment amount identified, and the date(s) the initial amount was communicated to the Provider and to SCDHHS PI.
(2) The modified overpayment amount identified, after appeals and reconsiderations, and the date(s) the modified amount was communicated to the Provider and SCDHHS PI.
(3) The final overpayment amount, after settlements, negotiations, and the accounts receivable is set for collection, and the date(s) the final amount was communicated to the Provider and SCDHHS PI.
(4) Overpayment amount recovered during each reporting quarter.
(5) If the overpayment is a result of fraud or waste/abuse.
(6) A running total of amount recovered until the overpayment is recovered in full.
(7) The date the overpayment was recovered in full and communicated to SCDHHS PI.
All Provider overpayments will remain on the Overpayments List until the identified amount is $0.00, or the amount is recovered in full. The MCO will remove Provider from the Overpayments List after the total recovered amount is reported on the MCO Fraud, Waste and Abuse Quarterly Report. The Overpayments List is located on each MCO's SharePoint site, in the "Lists" section.

Reporting Provider Exclusions, Terminations for Cause, and Reinstatements

Within the secure PI website, PI will document their actions taken to exclude or terminate a Provider for cause or reinstate a Provider that was either excluded or TFC, on the Exclusion and Termination for Cause list and upload copies of the notices/letters. PI staff will notify the MCO via email that the PI website has

been updated. The MCO will document the actions they take against the Provider on the list on the secure PI website. The MCO must report excluded and/or terminated for cause Providers to PI on the Provider Notice Form and report this as a Case on their Provider Termination/Denial for Cause Monthly Report. PI staff will notify the MCO via email that the PI website has been updated. The MCO will document the actions they take against the Provider on the list on the secure PI website.

At any time during a review conducted by PI, PI may refer the review to the MCO to conclude the MCO portion of the review. Any Case that PI refers to the MCO should be recorded on the MCO Fraud, Waste, and Abuse Quarterly Report.

1) Provider Exclusions and Terminations for Cause Lists are located on the PI SharePoint site at MCO DASHBOARD
2) Instructions for reporting Provider Exclusions, Terminations for Cause, and Reinstatements can be found at MC Health Plan Program Integrity – Instructions for Reporting Provider Exclusion Terminations for Cause Reinstatements – All Documents or through the following link at MC Health Plan Program Integrity - Instructions for Reporting Provider Exclusions_Terminations for Cause and Reinstatements - All Documents.

Reporting Provider Payment Suspension

1) Provider Payment Suspension List is located on the PI SharePoint site and MCO DASHBOARD.
2) Instructions for reporting Provider Payment Suspension can be found at MC Health Plan Program Integrity – Instructions for Reporting Provider Payment Suspensions – All Documents or through the following link at MC Health Plan Program Integrity - Instructions for Reporting Provider Payment Suspensions - All Documents.

3) An example of an MCO Payment Suspension Letter can be found at MC Health Plan Program Integrity – Payment Suspension Letter Template (For MCOs) – Folders or through the following link at MC Health Plan Program Integrity - Forms and Letters.

Reporting Provider Prepayment Reviews

PI staff will notify the MCO via email when a Provider is placed on prepayment claims review by the Department, and the DHHS Prepayment List maintained on the secure PI website has been updated. The MCO will document their activity, and any actions they take against the Provider, on the Prepayment list located on the secure PI website. A full prepayment claims review will include all claims submitted for payment and will not be limited by a particular procedure code or random sample.

The MCO may not remove a provider from a PI initiated prepayment claims review until PI documents the PI prepayment review case is closed on the DHHS Prepayment List. PI will notify the MCO via email of PI prepayment claims review case closures after documenting the case closures on the DHHS Prepayment List.

1) Provider Prepayment Review List is located on the PI SharePoint site at MCO DASHBOARD.
2) Instructions for reporting Provider Prepayment Reviews can be found at MC Health Plan Program Integrity – Instructions for Reporting Provider Prepayment Reviews – All Documents or through the following link at MC Health Plan Program Integrity - Instructions for Reporting Provider Prepayment Reviews - All Documents.

Annual Strategic Plan

The completed matrix and any applicable supporting documentation shall be uploaded to the MCO's SharePoint site, in the Shared Documents Library, in the "Strategic Plans" folder, in the applicable year's folder.

The annual Strategic Plan matrix can be found at the PI SharePoint site in the MC Health Plan Program Integrity – Reports/Annual Plans Document Library or through the following link at MC Health Plan Program Integrity - Annual Strategic Plan Matrix - All Documents.

Beneficiary Explanation of Medicaid Benefits (BEOMB) Letter and Notification Referral

The Department administers a Beneficiary Explanation of Medical Benefits (BEOMB) Program, as required by 42 CFR § 433.116, which gives Members the opportunity to participate in the detection of Fraud and Abuse.

The Department has created a template letter that is generated and sent to a randomly selected number of Members each month listing all non-confidential services paid during the preceding month. Examples of these BEOMB letters are located on the PI SharePoint site in MC Health Plan Program Integrity - Beneficiary Explanation of Medicaid Benefits (BEOMB) Letter Examples - Folders.

The purpose of the BEOMB is to request Members to verify that they received the listed services, including any applicable pharmacy services. BEOMBs include Fee-for-Service and Managed Care Services. A stamped self-addressed envelope is provided for Member's response.

When a Member returns a BEOMB to PI with the assertion that some or all the MCO-Covered Services were not received, the PI reviewer will initiate and send a OMB Notification Referral to the individual MCO site(s). PI staff will notify the MCO of the referral upload to the secure PI website via email.

Targeted Beneficiary Explanation of Medicaid Benefits (BEOMB) Permissions Request Form

The MCO may also conduct a special targeted BEOMB where Members are surveyed to verify whether services were received from a Provider under MCO review. Prior to the mailing, the MCO must first request approval from PI to conduct a Targeted BEOMB by completing the Targeted BEOMB Permissions Request Form which is located on the PI SharePoint site at MC Health Plan Program Integrity - Targeted Beneficiary Explanation of Medicaid Benefits (BEOMB) Permissions Request Form - Folders.

The MCO must complete the following steps:

1. The MCO must complete the Targeted BEOMB Permissions Request Form, and upload it to the MCO's SharePoint site, in the Shared Documents Library, in the "Targeted BEOMB Permissions Requests" folder, in the applicable year's folder.
2. Once the form is uploaded, the MCO will send an email to omco@scdhhs.gov to notify PI of the upload.
3. The PI Review staff will respond to the permission request within five (5) business days to notify the MCO contact person if PI approves the request for the Targeted BEOMB.
4. If PI approves the request, the MCO must then upload the letter template to their individual Member Material website in SharePoint for the Bureau of Managed Care approval. The MCO should indicate the date PI granted approval by using the State Approved section on the bottom of the form in the footer section.
5. If the Bureau of Managed care approves the request, the MCO will generate the BEOMB run and mail the letters to the Members, along with a stamped self-addressed envelope.

6. When the Member returns a letter, any response other than a "yes" must be logged to the case for record retention purposes.
7. If the case is later referred to PI and VAMPF as a fraud referral, all responses that were investigated must be forwarded as part of the referral.

Section 11.2

Annual Compliance Plan

The completed matrix and supporting documentation shall be uploaded to the MCO's SharePoint site, in the Shared Document Library, in the "Compliance Plans" folder, in the applicable years folder.

The annual Compliance Plan matrix can be found at the PI SharePoint site in the MC Health Plan Program Integrity – Reports/Annual Plans Document Library or through the following link at MC Health Plan Program Integrity - Annual Compliance Plan Matrix - All Documents.

Section 11.4

Terminations for Cause Referral Form

When the MCO identifies reasons consistent with the terminations for cause rationale listed in the *CMS CPI-CMCS Informational Bulletin dated January 20,2012, SUBJECT: Affordable Care Act Program Integrity Provisions – Guidance to States- Section6501 – Termination of Provider Participation under Medicaid if Terminated under Medicare or other State Plan,* they shall complete this form as thoroughly as possible.

The completed form and supporting documentation shall be uploaded to the MCO's SharePoint site, in the Shared Documents Library, in the "Referral Form

TO DHHS PI" folder. Once the form is uploaded, send an email to omco@scdhhs.gov to notify Program Integrity (PI) of the upload. The form instructions and template can be found at the PI SharePoint site in the MC Health Plan Program Integrity – Forms and Letters Document Library or through the following link at MC Health Plan Program Integrity - Forms and Letters.

Vetting Form

The Vetting Form is used by PI to request the MCO to vet paid encounter claims when the Department has identified an overpayment made by the MCO to a Provider. This process will help ensure each claim line is not reviewed twice, resulting in a duplicate overpayment for the Provider. The Vetting Form should include a description of the overpayment and the CCNs to identify the claims. To vet a review, PI will upload the Vetting Form to the secure PI website and indicate with an X "MCO Encounter Data Review" along with a Date Due Back. The MCO must validate the findings per PI's instructions on the Vetting Form or provide supporting comments of their objections or recommendations to the Department or its designee.

Once the MCO has completed Section F of the Vetting Form, they shall upload this completed form and supporting documentation to the MCO's SharePoint site, in the Shared Documents Library, in the "Vetting Forms" folder, in the applicable year's folder. Once the form is uploaded, send an email to the PI reviewer/investigator listed in Section A of the vetting Form and copy omco@scdhhs.gov to notify them of the upload.

Section 11.6

Verification of Services Provided (VOSP) Letter and Notification Referral

The Department administers a Verification of Services Provided (VOSP) Program, which gives Providers the opportunity to participate in the detection of Fraud and Abuse.

The Department generates a standardized VOSP letter a few times per year and sends it to select provider specialties where potential issues have been identified. The VOSP letter lists claims paid by the South Carolina Medicaid Program with dates of service where the Provider was identified as the rendering Provider. An example of a VOSP letter is located on the PI SharePoint site in MC Health Plan Program Integrity - Verification of Services Provided (VOSP) Letter Example - Folders.

The purpose of the VOSP is to request rendering Providers to verify that they were associated with the Providers listed along with the services provided during the listed date ranges. VOSPs include Fee-for-Service and Managed Care Services. A stamped self-addressed envelope is provided for Provider's response.

When a Provider returns a VOSP to PI with the assertion that they had no association with one or more of the Providers listed for some or all the MCO-Covered Services, the PI reviewer will initiate and send a VOSP Notification Form Referral to the MCO(s). This referral form is located on the PI SharePoint site in MC Health Plan Program Integrity - Verification of Services Provided (VOSP) Notification Form - Folders. PI staff will notify the MCO of the referral upload to the secure PI website via email.

Section 11.10

Statewide Pharmacy Lock-In Program Letters/ Instructions

SPLIP letter templates must be used by each MCO to notify members of their enrollment or removal from the SPLIP, provide members instructions about the SPLIP, and to notify a pharmacy of a member's SPLIP enrollment. The only

authorized modifications to the templates are annotated with brackets (<< >>) and highlighted in yellow. These sections must be modified by the MCO. The following letter templates and instructions can be found on the PI SharePoint site in the MC Health Plan Program Integrity - Pharmacy Lock-In Program.

1. MCO Pharmacy Lock-In Member Notification Letter
2. MCO Pharmacy Lock-In Member Instructions
3. MCO Pharmacy Lock-In Member Removal Letter
4. MCO Pharmacy Lock-In Pharmacy Notification Letter

After a Member is selected for enrollment in the SPLIP, a certified letter will be sent at least thirty (30) days before their Effective Date of enrollment. The letter will include:

- The Member name and Medicaid ID
- The six (6) month review period
- The "Effective Start" and "Termination Date"
- The pre-selected designated pharmacy
- Directions for changing the designated pharmacy to one of their choice.
- Program instructions
- Appeal Rights and directions on how to file the appeal.

If the Member opts to choose a different pharmacy as their sole Provider, they are given twenty (20) Days from the date of the Certified Notification Letter to call and request a pharmacy of their choice. After the Effective Date, all changes will require a request and approval.

DATA DEFINITIONS FOR PROGRAM INTEGRITY	
Descriptor	Definition
Data Mining	The process of electronically sorting Medicaid claims through statistical models and intelligent technologies to uncover patterns and relationships contained within the Medicaid claims activity and history to identify aberrant utilization and billing practices that are potentially fraudulent.
Debarment	Refers to the exclusion of certain persons from participation in contracts and subcontracts with Medicaid, or in projects or contracts performed with the

	assistance of and subject to the approval of SCDHHS, on the basis of a lack of responsibility.
Prepayment Review	Refers to the process where provider claims are reviewed prior to a receiving a payment for services rendered.
System for Award Management (SAM)	A no cost U.S. Government website to search for a provider/entity's registration and exclusion records.
Termination	SCDHHS or the MCO has taken an action to revoke a provider's Medicaid billing privileges, the provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there no exception on the part of the provider or SCDHHS or the individual MCO that revocation is temporary.
Termination for Cause	The revocation of a providers Medicaid billing privileges as a result of the providers abuse and/or misuse of the Medicaid Program. Examples include but are not limited to: falsifying information on their enrollment application, adverse licensure actions, engagement in fraudulent conduct, abuse/misuse of Medicaid billing privileges, and the provider is excluded from the Medicaid program.
Vulnerable Adult and Medicaid Provider Fraud (VAMPF) Unit	The division of the State Attorney General Office that is responsible for the investigation and prosecution of health care fraud committed by Medicaid providers. Formerly known as the Medicaid Fraud Control Unit (MFCU)

PI will generate a quarterly report that will review all Medicaid Member's claims for a six (6) month period. The report will analyze different weighted criteria as established by PI based on research; with most of them analyzing the use of pain medications. The report will then assign a score and rank the Member based on that score. The composite scores measures are listed in the chart (*Exhibit 20*) below.

The report will then select Members for enrollment into SPLIP based on a score determined by the SPLIP. The PI algorithm used to generate the criteria are as follows:

- FFS and Encounter Claims included
- Pharmacy Dispensed Dates: XX/XX/20XX - XX/XX/20XX (6 months) Voids Removed

- Excluded Members in Hospice, with a date of death or no longer Medicaid eligible.
- Excluded Members currently in the SPLIP. Only included Members with a Score > 0
- Excludes members with sickle cell disease (ICD9 codes 282.60 thru 282.9 and ICD10 codes D57.00 thru D57.1 and D57.20 thru D57.219 and D57.4 thru D57.819)
- Excluded Members Age <= 16 and ((Aid Category = 57 (TEFRA) or RSP

Exhibit 20- Composite Score Measures for Members in SPLIP

Criteria	Composite Score Measures		Score
1	CII Without Professional Claim in Previous Six (6) Months	Identifies any Member with a DEA Schedule II prescription without a professional Claim in the previous six (6) months. The professional Claims look back was not limited to the time period of this report.	1
2	Fifteen or More RX in Thirty (30) Calendar Days	Identifies Members with fifteen (15) or more prescriptions (any schedule) within a thirty (30) Calendar Day period. This measure is based on a rolling thirty (30) Calendar Days within the six (6) month time period of this report.	0.5
3	Five or More Controls in Thirty (30) Calendar Days	Identifies Members with five (5) or more DEA Schedule II-V prescriptions within a thirty (30) Calendar Day period. This measure is based on a rolling thirty (30) Calendar Days within the six (6) month time period of this report.	3
4	Two or More ER Visits In Thirty (30) Calendar Days and Controlled RX	Identifies Members with two (2) or more Non-Emergent ER visits within a thirty (30) Calendar Day period and a DEA Schedule II-V prescription within the same thirty (30) Calendar Days. This measure is based on a rolling thirty (30) Calendar Days within the six (6) month time period of this report: fac_revenue_cd = '0450','0451'	1

		OUTPAT_SERVICE_LEVEL = '1' OUTPAT_SERVICE_LEVEL was tagged to Encounter Claims from Diagnosis record based on primary diagnosis code.	
5	GT 3600 mg Oxycodone HCL in Thirty (30) Calendar Days	Identifies Members with more than 3600 mg of Oxycodone HCL (generic name for Oxycontin) in a thirty (30) Calendar Day period. This measure is based on a rolling thirty (30) Calendar Days within the six (6) month time period of this report. Total mg per prescription = strength * quantity dispensed	3.5
6	Two or More Out of State Pharmacies for Controls	Identifies Members with DEA Schedule II-V prescriptions from two (2) or more out of State pharmacies.	2
7	Two Controls From Two (2) Pharmacies within Two (2) Calendar Days	Identifies Members with two (2) or more DEA Schedule II-V prescriptions dispensed by two (2) different pharmacies on two (2) consecutive Calendar Days.	1
8	Suboxone within Six (6) Months	Identifies Members with Suboxone prescriptions during the time period of this report. generic_name = 'Buprenorphine Hydrochloride/Naloxone Hydrochloride'	1
9	Opioid Within Thirty (30) Calendar Days After Suboxone	Identifies Members with an opioid prescription within thirty (30) Calendar Days after a Suboxone prescription. Suboxone: generic_name = 'Buprenorphine Hydrochloride/Naloxone Hydrochloride') Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII'	10

10	Ten or More Pills Per Day For Controlled RX	Identifies Members with DEA Schedule II-V prescriptions allowing for ten (10) or more pills per Day. Master Form = Capsule or Tablet Qty_Dispensed / Days_Supply >= 10	2
11	Pill Count for Controls GT 600	Identifies Members with a pill count exceeding 600 for all DEA Schedule II-V prescriptions dispensed during the six (6) month time period of this report. Master Form = Capsule or Tablet	5
12	History of Drug Dependence with Benzo or Opiate RX	Identifies Members with a drug dependence diagnosis code and a Benzodiazepine or Opiate prescription during the six (6) month time period of this report. Diagnosis code like '304*' - checked all diagnosis codes on professional and hospital Claims Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII' Benzodiazepines: Redbook_int_ther_class like '*BENZODIAZEPINES*' and Redbook_dea_class_cd = 'CIV'	2
13	History of Poison Overdose with Benzo or Opiate RX	Identifies Members with a poisoning/overdose diagnosis code and a Benzodiazepine or Opiate prescription during the six (6) month time period of this report. Diagnosis code = '960' to '9799' - checked all diagnosis codes on professional and hospital Claims Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII' Benzodiazepines: Redbook_int_ther_class like '*BENZODIAZEPINES*' and Redbook_dea_class_cd = 'CIV'	1.5

14	Five or More Prescribers	Identifies Members with five or more prescribers during the six (6) month time period of this report. All prescriptions included.	0.5
15	Two or More Opioid Prescribers	Identifies Members with two or more prescribers issuing an opioid prescription during the six (6) month time period of this report. Opiates: Redbook_dtl_ther_class_cd like '280808*' and Redbook_dea_class_cd = 'CII','CIII'	1
16	Three or More Prescribers for Controlled Substance	Identifies Members with three (3) or more prescribers issuing a controlled substance (DEA Schedule II-V) during the six (6) month time period of this report.	1
17	Four or More Pharmacies	Identifies Members with drugs dispensed by four (4) or more pharmacies during the six (6) month time period of this report. All prescriptions included.	0.5
18	Two or More Pharmacies for Controlled Substance	Identifies Members with controlled substances (DEA Schedule II-V) dispensed by two or more pharmacies during the six (6) month time period of this report.	1
19	Three or More Controlled Substances and Drugs of Concern	Identifies Member with three (3) or more drugs between controlled substances (DEA Schedule II-V) and other drugs of concern. Other drugs of concern include tramadol, cyclobenzaprine, methocarbamol, tizanidine and metaxalone. Unique count of generic_name > 3	1
20	On Cocktail Reports	Identifies Members also found on the "Holy Trinity" or "The Cocktail" reports for the same six (6) month time period. These reports	3

identify Members who were dispensed all components of a known drug cocktail during a thirty (30) Calendar Day period.

Total Composite Score = 41.5

The Department can revise these criteria as needed; for example, to include current drugs being sought by abusers according to national trends. The report will also automatically assign a Lock-In Pharmacy for the Member based on the pharmacy they have utilized the most during the six-month period.
Each MCO's SharePoint site in the "Lists" section, houses a live Member databank that must be maintained by the MCO on a daily basis over the course of the Member's lock in period. PI will upload the selected Members on the secure PI website each quarter and will notify the MCO by email when this has been completed. The email will include the total number of selected Members uploaded and the six (6) month review Claim period. The MCO must record all the Member's activities on the secure PI website.
These additional Members will be added on the secure PI website by the MCO (or the MCO may ask for assistance from PI if it is a large upload). For these additional Members, the MCO will assign its Plan name in the "Selected By" field to indicate the Member was chosen by the MCO and not the Department. The MCO should indicate the date PI granted approval by using the State Approved section on the bottom of the form in the footer section.

Pharmacy Changes/Additions

When a Member is granted a pharmacy change, the Member's record on the secure PI website must reflect the change. It is important to add the new pharmacy and terminate the old one, and to update the pharmacy information, date for last pharmacy change, and reason why there was a pharmacy change.

SPLIP Timeline

The Member must be locked into a designated pharmacy no later than ninety (90) Calendar Days after the initial quarterly referral from the Department unless the Member files an Appeal. The established timeline below (*Exhibit 21*) is recommended.

Exhibit 21- Statewide Pharmacy Lock-In Program Schedule

Lock-in Schedule	
Date	Task
March 1	Run Report based on Pharmacy Dispensed Date 07/1/2020 to 12/31/2020 (Request to run can be made during the last two [2] weeks.)
March 1 to March 30	Thirty (30) Calendar Days for the Pharmacy Dept. to complete the Clinical Component
April 1 to April 30	Thirty (30) Calendar Days for PI LI to complete data entry in MMIS and prepare for mailing
May 1	Notification Letter to Beneficiaries (twenty [20] Calendar Days to respond)
May 20	Letter to selected Pharmacy (ten [10] Calendar Days to respond)
June 1	Effective Lock-In Date Run Report based on Pharmacy Dispensed Date 10/1/2020 to 3/31/2021. (Request to run can be made during the last two [2] weeks in May) June 1 to June 30 – Thirty (30) Calendar Days for the Pharmacy Dept. to complete the Clinical Component.
July 1 to July 31	Thirty (30) Calendar Days for PI LI to complete data entry in MMIS and prepare for mailing.
August 1	Notification Letter to Beneficiaries (twenty [20] Calendar Days to respond)
August 20	Letter to selected Pharmacy (ten [10] Calendar Days to respond)
September 1	Effective Lock-In Date Run Report based on Pharmacy Dispensed Date 1/1/2021 to 6/30/2021. (Request to run can be made during the last two [2] weeks in August.)
September 1 to September 30	Thirty (30) Calendar Days for the Pharmacy Dept. to complete the Clinical Component.

October 1 to October 30	Thirty (30) Calendar Days for PI LI to complete data entry in MMIS and prepare for mailing.
November 1	Notification Letter to Beneficiaries (twenty [20] Calendar Days to respond)
November 20	Letter to selected Pharmacy (ten [10] Calendar Days to respond)
December 1	Effective Lock-In Date Run Report based on Pharmacy Dispensed Date 4/1/2021 to 9/30/2021. (Request to run can be made during the last two [2] weeks in November)
December 1 to December 31	Thirty (30) Calendar Days for the Pharmacy Dept. to complete the Clinical Component.
January 1 to January 31	Thirty (30) Calendar Days for PI LI to complete data entry in MMIS and prepare for mailing.
February 1	Notification Letter to Beneficiaries (twenty [20] Calendar Days to respond)
February 20	Letter to selected Pharmacy (ten [10] Calendar Days to respond)
March 1	Effective Lock-In Date

SPLIP Member Transfers

A transfer occurs when a Member enrolling in an MCO (receiving Managed Care) was previously enrolled under FFS or a different MCO Provider. PI initiates these transfers. The following pertain to transfers and documenting the Member record on the secure PI website:

- Do not delete or overwrite the dates in the "Dt CertLtr Sent to Member" column; this represents the Date the Member was mailed the initial SPLIP enrollment notification letter by someone other than the receiving MCO. This date WILL NOT change.
- Do not delete or overwrite the dates in the "UNIVERSAL 2 Yr Eff Start Dt" and "UNIVERSAL 2 Yr End Dt" columns; this is the two (2) year time period assigned to the Member. Once the Member has been enrolled in the Program, this term WILL NOT change, regardless of transfers between MCOs or in and out of Medicaid eligibility.
- The receiving MCO CANNOT add additional months to the Universal two (2) year time period.
- If the receiving MCO chooses to send a letter to the transferred Member advising them of their continued enrollment in the LI Program, the

"UNIVERSAL 2 Yr End Dt" will remain the same as given the Member in their initial enrollment notification letter. The receiving MCO WILL NOT RESTART the Universal two (2) year period when it receives the transferred Member.

- The receiving MCO MUST enter the date it received and entered the transferred Member in the "Transfer Completed" column.
- Place the Member in lock-in status as soon as possible and continue with the effective dates and the selected pharmacy indicated in the transferred record.
    - The Member is not given the option to change their selected pharmacy of record. However, as a newly enrolled Member in the receiving MCO, the Member may select a new pharmacy.
    - The receiving MCO will document this pharmacy change in the Member's record.

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 status will then be changed to pending (P) and a YES will be placed in the transfer column.

Section 11.12

Provider Termination/Denial for Cause Monthly Report

This report is required for monthly provider termination for cause reporting to Program Integrity. The Monthly Termination/Denial for Cause Report documents any Provider TFC or denial for cause that the MCO imposed during the previous month.

When the MCO terminates a Provider for cause or denies a Provider from participating in the MCO's Provider network for cause, the MCO shall report the Provider's TFC or denial for cause on their Monthly Termination/Denial for Cause Report and upload a copy of the Provider's Termination for Cause Letter to the secure PI website. The Monthly Termination/Denial for Cause Report is

due on the 15th of the following month and must be uploaded to the appropriate folder within the secure PI website. (For example, January data will be reported on the February 15th report.) If the 15th falls on a State Holiday or weekend, it will be due the following Business Day.

The completed report shall be uploaded to the MCO's SharePoint site, in the "Reports" section, in the "Termination Report" folder, in the applicable year's folder. The Monthly Termination/Denial for Cause Report can be found at the PI SharePoint site in the MC Health Plan Program Integrity – Reports/ Annual Plans Document Library or through the following link at MC Health Plan Program Integrity - Reports / Annual Plans.

SECTION 12
MARKETING REQUIREMENTS

Section 12.6

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 MCOs 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 of the event.

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

Events on the spreadsheet should be listed in the order of submission, but each column heading has a sorting option available. An example of the log may be found in *Exhibit 23* below.

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.

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 in *Exhibit 22*. 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

Marketing Material Submission Requirements

All marketing, educational materials, online materials, and social media requests must be uploaded to the MCO's SharePoint site in the PR and Member Material Review library. All files submitted should have the standard naming convention as set by SCDHHS. For Document Labeling specifics and Document Label Examples, please refer to the chart below. SCDHHS must approve all Marketing Materials prior to public use; the naming convention must be visible on all approved written Marketing Materials.

Document Labeling

MCOs will be expected to follow the document labeling criteria for all marketing material submissions, as detailed below.

- *Example: Plan Code + Date of 1st submission + Type-Sequence # +Subtype + Version+ A*

Plan Code	
	ATC (Absolute Total Care)
	BC (Healthy Blue by BlueChoice)
	HHP (Humana)
	MO (Molina)
	FC (Select Health)
Date	
	MMDDYYYY
Type	
	M=Member
	P=Provider
	PR=Marketing Material
Appending Type	

	S=Spanish
Sequence #	**Submission Type**
1	First new submission of the day
2	Second new submission of the day
3	Third new submission of the day and so on…
Original Sequence.1	1st Resubmission
Original Sequence.2	2nd Resubmission
Original Sequence.3	3rd Resubmission
Subtype	
	BM (Branding Material)
	BS (Broadcast Script)
	MS (Marketing Script)
	NG (Nominal Gift)
	TS (Telephone Script)
	WM (Written Material)
Version	**Version Definition**
N (New)	A first-time submission for review.
U (Updated)	A previously approved submission being updated for review.
R (Resubmission)	A previously denied submission being corrected for review.
Attestation	**Definition**
A (Attestation)	A minimal change on previously approved material review. The material has no content changes.

Document Label Examples

New Member Material

- *Example: ATC-01182015-M-1-WM-N*
- *Example Definition: Absolute Total Care Member written material submission on 1/18/2015 initial submission.*

Updated Member Material

- *Example: ATC-01182015-M-1.1-WM-UExample*
- *Example Definition: Absolute Total Care Member written material submission on 1/18/2015 1st update.*

Resubmissions

- *Example: ATC-01182015-M-1.1-WM-R*
  Example Definition: Absolute Total Care Member written material submission on 1/18/2015 1st resubmission.

Attestation

- *Example: ATC-01182015-M-1.2-WM-U-A*
- *Example Definition: Absolute Total Care Member written material submission on 1/18/2015 2nd update with minimal change.*

Document Label Examples (Spanish Materials)

New Spanish Member Material

- *Example: ATC-01182015-M-1-S-WM-N*
- *Example Definition: Absolute Total Care Spanish Member written material submission on 1/18/2015 initial submission.*

Updated Spanish Member Material

- *Example: ATC-01182015-M-1.1-S-WM-U*
- *Example Definition: Absolute Total Care Spanish Member written material submission on 1/18/2015 1st update*

Attestation

- *Example: ATC-01182015-M-1.2-S-WM-U-A*
- *Example Definition: Absolute Total Care Spanish Member written material submission on 1/18/2015 2nd update with minimal change.*

Exhibit 22: 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. ****

Exhibit 23: 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 12.13

Member Communication

New or revised Member materials must be uploaded to the MCO's SharePoint site in the PR and Member material review library. This file should include at a minimum, a final draft version, proof of reading level, a redlined version of the document (if applicable), and any required attestations needed for non-English language translations. All files submitted should follow the naming convention outlined in Section 12.4 of this guide.

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

Psychiatric Residential Treatment Facility (PRTF) Report

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

GME Report Template

This 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

This report summarizes 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 example, a February 2016 Data Period would be Reported with the other March data due to be submitted April 15th.

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 14.6

Encounter Data

The MCO may submit paid and zero paid Encounters daily. Daily Encounter submissions may take place any Day of the week, special instructions are included below for Friday, Saturday, or Sunday submission. The limits to daily file submission are:

1. Five thousand (5,000) record limit per file
2. Fifteen (15) files are allowed each Day (maximum submission for any single Day Monday through Saturday is 75,000 records).
3. Sunday submissions are not allowed.
4. Void Encounters must be submitted in a separate file after the original Encounter has received a 277CA response indicating the department's acceptance of the original Encounter. Void and Regular Encounters may be submitted on the same Day. If the MCO elects to send both void and regular Encounters on the same Day, they must be in separate files from each other. All void Encounters must be in one (1) file and regular Encounters must be in a second file. Void and regular Encounters must not be comingled within the same file.

Encounter data submitted to SCDHHS in most instances must appear in the same manner that the original Claim was submitted and paid by the MCO. SCDHHS will allow split Encounters in the following instances:

1. 837I Encounter: The original institutional Claim has more than fifty (50) lines of data and/or billed and/or paid amounts on the Claim exceed $9,999,999.99.
2. 837P Encounter: The original professional Claim has more than eight (8) lines of data and/or billed and/or paid amounts on the Claim exceed $99,999.99 on any line of the Claim.

Section 14.10

Encounter Quality Initiative (EQI) Report Template

MCOs are required to submit quarterly and annual Encounter Quality Initiative (EQI) reports to SCDHHS. SCDHHS will provide instructions and templates for this report in December of each year prior to their submission due dates.

Quarterly EQI reports are due within one hundred and twenty-one (121) Days of the end of each calendar quarter. The annual EQI report will be due the third Friday in January of each year. If there are delays in the MCO's receipt of the previous quarter's EQI analysis, SCDHHS will extend the time frame for EQI submission by thirty (30) Days from the MCOs receipt of the EQI results. The reporting schedules referenced in *Exhibit 24* are used for quarterly and annual EQI reporting.

Exhibit 24- Quarterly & Annual EQI Reporting Schedules

Quarterly EQI Reporting Schedule*			
Service Dates of EQI Report	Through Paid Date	EQI TEMPLATE DELIVERY MONTH	EQI Report Due Date
January 1 – March 31	Claims Paid through June 30	June	July 31
January 1 – June 30	Claims Paid through Sept 30	September	October 31
January 1 – September 30	Claims Paid through December 31	Early January	January 31
January 1 – December 31	Claims Paid through March 31	March	April 30
Annual EQI Reporting Schedule*			
Service Dates of EQI Report	Through Paid Date	EQI TEMPLATE DELIVERY MONTH	EQI Report Due Date
July 1- June 30 (Previous Fiscal Year)	Claims Paid through December	Early January	Third Friday in January in years when the month has four Fridays; Fourth Friday in January in years when the month has five Fridays
*Encounter data must be submitted prior to the 25th of the month for SCDHHS and the SCDHHS Actuary to have the data for use in EQI analysis.			

Should the due date specified above fall on a weekend or State holiday, the EQI report is due the prior Business Day (i.e., if the Day to submit the EQI report falls on a Saturday, the EQI Report is due the Friday prior at noon (12 PM EST) or if that Friday is a State holiday, the EQI Report is due the previous day (Thursday)).
SCDHHS will use the MCO's Encounter data, or other method of data completion verification deemed reasonable by SCDHHS, to verify the completeness and accuracy of the EQI report in comparison to the MCO's Encounter Claims.
The EQI data reporting periods will be on a cumulative year-to-date basis. (i.e., fourth (4th) quarter of calendar year 2012 will be all incurred Claims and Membership for the entire calendar year 2012).
EQI reports must be uploaded to the MCO's SharePoint EQI library. Additionally, the MCO must notify their SCDHHS Contract Monitor that the information has been uploaded to the site. The naming convention of the report must be as follows:

- *Calendar year of report - Calendar quarter of report/annual report - MCO Name - EQI submission*
- *Example: 2015Q1 ACME MCO EQI Submission*

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. SCDHHS may request that the MCO submit other documentation that is also required for NCQA's health plan accreditation and will communicate with the MCO reasonable timeframes to correspond with the creation of additional documentation, if needed.

Section 15.4

HEDIS and CAHPS Reports

These reports are NCQA defined reports and should follow the reporting requirements NCQA utilizes. Data must be uploaded to the MCOs SharePoint site in the Annual Report Library in the folder [YR] HEDIS CAHPS APM. The table below (*Exhibit 25*) reflects annual submission requirements. An example of the attestation form for these reports must accompany them and is reflected in *Exhibit 26*.

Exhibit 25- Annual CAHPS and NCQA Member Level Data Files

ANNUAL CAHPS AND NCQA MEMBER LEVEL DATA FILES				
Submission	Required Naming Convention	Required File Format	Notes	Due Date
CAHPS Child Survey	[PlanName]_CAHPS_Child Instrument_RY [Two Digit Reporting Year].pdf	PDF	Member satisfaction survey Child instrument	1-Jul
CAHPS Child Rates	[PlanName]_CAHPS_Child_RY [Two Digit Reporting Year].pdf	PDF	Member satisfaction survey. The final data submission of the annual CAHPS Child survey data to NCQA.	1-Jul
CAHPS Child Individual Responses	[PlanName]_CAHPS_Child_Ind_RY [Two Digit Reporting Year].txt	Text	Member satisfaction survey. Individual-level CAHPS Child data with data layout.	1-Jul
CAHPS Child Individual Responses	PlanName]_CAHPS_Child_Ind_RY [Two Digit Reporting Year].csv	CSV	Member satisfaction survey. Individual-level CAHPS Child data with data layout.	1-Jul
CAHPS Child CCC Survey	[PlanName]_CAHPS_CCC Instrument_RY [Two Digit Reporting Year].pdf	PDF	Member satisfaction survey CCC instrument	1-Jul
CAHPS Child CCC Rates	[PlanName]_CAHPS_CCC_RY [Two Digit Reporting Year].pdf	PDF	Member satisfaction survey. The final data submission of the annual CAHPS Child CCC – General Population survey data to NCQA.	1-Jul
CAHPS Child CCC Rates	[PlanName]_CAHPS_CCC_RY [Two Digit Reporting Year].csv	CSV	Member satisfaction survey. The final data submission of the annual CAHPS Child CCC – General Population survey data to NCQA.	1-Jul
CAHPS Child CCC Individual Responses	[PlanName]_CAHPS_CCC_Ind_RY [Two Digit Reporting Year].txt	Text	Member satisfaction survey. Individual-level CAHPS Child CCC – General Population data with data layout.	1-Jul

CAHPS Adult Survey	[PlanName]_CAHPS_Adult Instrument_RY [Two Digit Reporting Year].pdf	PDF	Member satisfaction survey Adult instrument	1-Jul
CAHPS Adult Rates	[PlanName]_CAHPS_Adult_RY [Two Digit Reporting Year].pdf	PDF	Member satisfaction survey. The final data submission of the annual CAHPS Adult survey data to NCQA.	1-Jul
CAHPS Adult Individual Response	[PlanName]_CAHPS_Adult_Ind_RY [Two-Digit Reporting Year].txt	Text	Member satisfaction survey. Individual-level CAHPS Adult data with data layout.	1-Jul
CAHPS Adult Individual Response	[PlanName]_CAHPS_Adult_Ind_RY [Two-Digit Reporting Year].csv	CSV	Member satisfaction survey. Individual-level CAHPS Adult data with data layout.	1-Jul
CAHPS Vendor Final Analysis	[PlanName]_CAHPS_Final_Adult_RY [Two-Digit Reporting Year].pdf	PDF	The final report that the CAHPS vendor produces, typically analyzing data; identifying strengths and opportunities; and cross-tabulating responses.	31-Jul
CAHPS Vendor Final Analysis	[PlanName]_CAHPS_Final_Child_RY [Two-Digit Reporting Year].pdf	PDF	The final report that the CAHPS vendor produces, typically analyzing data; identifying strengths and opportunities; and cross-tabulating responses.	31-Jul
CAHPS Vendor Final Analysis	[PlanName]_CAHPS_Final_CCC_RY [Two-Digit Reporting Year].pdf	PDF	The final report that the CAHPS vendor produces, typically analyzing data; identifying strengths and opportunities; and cross-tabulating responses.	31-Jul

Exhibit 26: 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:	

The MCO must submit HEDIS information as specified in *Exhibit 27*. Data must be uploaded to the MCOs SharePoint site in the Annual Report Library in the folder [YR] HEDIS CAHPS APM. If additional Quality performance measures are required in the future, the Department will provide notice to the Health Plans of the new requirements.

Exhibit 27- Annual HEDIS Data Files

ANNUAL HEDIS DATA FILES				
Submission	Required Naming Convention	Required File Format	Notes	Due Date
HEDIS Certification Letter	[PlanName]_HEDIS_Certification_RY [Two Digit Reporting Year].pdf	PDF	Signed certification letter attesting to the Accuracy and Completeness of audited HEDIS data and the FAR.	July 1
HEDIS Rates	[PlanName]_ HEDIS_RY [Two Digit Reporting Year].xls	XLS	The auditor-locked workbook that contains the audit review table, as well as a tab for each HEDIS measure.	July 1
HEDIS Rates	[PlanName]_ HEDIS_RY [Two Digit Reporting Year].csv	CSV	The auditor-locked workbook that contains the audit review table, as well as a tab for each HEDIS measure.	July 1
South Carolina Specific Final Audit or Report (FAR)	[PlanName]_FAR_RY [Two-Digit Reporting Year].pdf	PDF	Final auditor report from the MCO's HEDIS auditor. Must include South Carolina specific medical record review and South Carolina specific supplemental data sources.	July 31

Section 15.6

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 in *Exhibit 28*:

Exhibit 28: 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 15.7

Patient Centered Medical Home (PCMH)

All PCMH reporting should be submitted in the MCOs SharePoint site monthly in the library labeled NCQA PCMH Data to ensure that SCDHHS and its contractor can reimburse the plans' timely and accurately at the end of the quarter. A copy of the reporting schedule can be found in *Exhibit 29*.

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

PCMH reporting must have the following naming conventions:

1. Regular Submission: PlanName_PCMH_FY#_Qtr#_Month
    a. *Example: If the submission is for the February 2024 PCMH data submission, the file name would be: ACMEMCO_PCMH_FY2025_Qtr3_February.*
2. Retro Submission: PlanName_PCMH_FY#_Qtr#_Month_Retro
    a. *Example: If the submission is for a retroactive submission of PCMH data for October 2024 PCMH data submission, the file*

name would be:
ACMEMCO_PCMH_FY2025_Qtr2_October_Retro.

Corrected files should be resubmitted within the same quarter, if at all possible. If submitted after the 15th of the last month of a quarter, these corrected files will be processed for payment during the next quarter.

Example: If the MCO is submitting Q1-FY2025 (July 2024 – September 2024) data, under the new Policy, the MCO can additionally submit qualified practice Membership data for Q4- FY2025 (April 2024 – June 2024), but not prior to this time period.

Exhibit 29- PCMH Incentive Payment Reporting Schedule

	Plan Submitted Data		Recipient Data for Verification		NCQA Data for Verification		Processing	Final Reports		
	Time Period	Submitted by the 15th	Time Period	Ready for Use by the 18th	Time Period	Ready for Use by the 8th	Time period	Report Type	Includes	Due Back to DHHS
Fiscal Year Quarter 3	January	February								
	February	March								
	March	April	April	May	April	May	4 weeks (May 15 - June 15)	Final Payment Full Quarter	Jan, Feb, and March data and payment numbers	June 15
Fiscal Year Quarter 4	April	May								
	May	June								
	June	July	July	August	July	August	4 weeks (August 15 - September 15)	Final Payment Full Quarter	April, May and June data and payment numbers	September 15
Fiscal Year Quarter 1	July	August								
	August	September								
	September	October	October	November	October	November	4 weeks (November 15 - December 15)	Final Payment Full Quarter	July, Aug and Sept data and payment numbers	December 15
Fiscal Year Quarter 2	October	November								
	November	December								
	December	January	January	February	January	February	4 weeks (February 15 - March 15)	Final Payment Full Quarter	Oct, Nov and Dec data and payment numbers	March 15

Member Incentive Form

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

The MCO must upload the completed form to their SharePoint.

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

Field definitions are provided below. A copy of the incentive form can be found in *Exhibit 30*. 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 (Implementation year)*

Exhibit 30- MCO Member Incentive Request Form

REQUIRED FIELDS FOR MEMBER INCENTIVES REQUEST FORM	
Requestor	Person completing form.
New or Existing Service Request?	Enter "New " if this is a new incentive. Enter "Existing" if this is currently a service with modifications/updates.
Implementation Date	If this incentive was submitted previously, enter the date(s) previously submitted. If this is a new incentive, enter the date of submission.
Additional Service Request Name	Name or title/subject matter of this member incentive request.
Background and Rationale	Complete description of problem statement (if applicable) and reason for request, as well as rationale supporting the selection of this specific member incentive. Why is it thought that the service will be successful or helpful?

Objectives	Statement of what the MCO is trying to accomplish with this additional service request. What exactly is being offered? Include details such as how many items are included, what is included, when the service is offered, where the service if offered, and how. Is there a vendor? What is the process for offering this service from start to finish?
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? What will be used to gather the data to support the effectiveness of this service?
Marketing Strategy for this service (Method, frequency etc.)	Define the marketing strategy, to include the exact methods and frequency used to market this service.
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 the completion of the measurement period, the MCO must provide post-intervention performance data, cost per service, and a yearly projection.
Subject Population/Comparator	The population that you are targeting for this intervention; please be specific. Examples include the following: age grouping/dates of enrollment/ diagnoses/ procedural codes.
Cost for service and yearly projection	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.
Procedure Code (required)	Enter the procedure code(s) for the service being provided.
Ineligible Criteria	Define reasons why someone may be removed or ineligible for the service, included, but not limited to, age or population-specific ineligibility criteria. *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; this can include data that shows the program was unsuccessful or had challenges.

Section 15.8

Alternative Payment Models (APM)

To qualify as an APM, a network contract must have some component of payment linked to Provider performance. MCOs are encouraged to pursue innovation in the pursuit of negotiating value-oriented contracts. Generally, APMs will be consistent with one of the following LAN Categories:

- Category 1: As defined by LAN, includes fee-for-service payments that are not linked to Quality or value. These Provider contracts are not considered APMs.
- Category 2A & 2B: Payments for infrastructure and operations (2A) and reporting (2B) are not considered APM payments by the Department.
- Category 2C & 2D: Provider contracts that include rewards or rewards & penalties for performance shall be considered APM contracts.
- Category 3: Bundled and episode of care payments shall be considered APM contracts, so long as Quality of care requirements are included in the Provider contract.
- Category 4: Sub-capitation arrangements shall be considered APMs, so long as Quality of care requirements are included in the Provider contract.

Annually, no later than April 30, each MCO shall submit to the Department a certification of the percentage of payments made pursuant to Alternative Payment Models and will include a listing of amounts associated with each LAN category listed above. The Contractor will use the Department's APM template to calculate the APM by dividing the total dollars paid pursuant to an APM by the total dollars spent by the MCO on healthcare services.

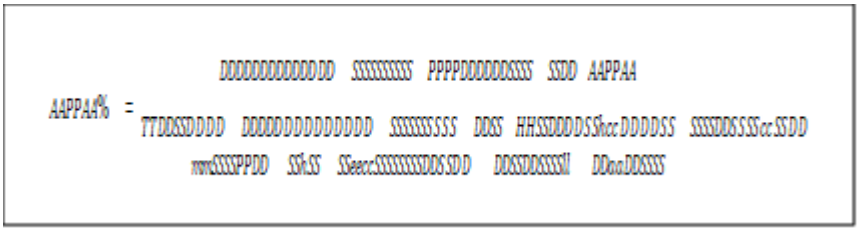
Payments for the following services may be excluded from the APM calculation:

- Claims paid through the pharmacy Benefit.
- Claims made to durable medical equipment Providers.
- Payments made to Federally Qualified Health Centers (FQHCs) based on the Prospective Payment System (PPS)

If, after the submission of the APM percentage to SCDHHS, the MCO finds that extenuating circumstances prevented the MCO from achieving the APM target due to SCDHHS Policy changes, the MCO may request for a reconsideration such that Claims costs for those Providers to be excluded from the denominator of the APM calculation (*Exhibit 31*).

The APM calculation should include all Claims or capitation payments with a date of service during the measurement period (January 1 through December 31) that are received by the MCO by March 31.

Exhibit 31- Alternative Payment Models (APM) Calculation



Information on the APM report requirements can be found in the chart (*Exhibit 32*) below. Data must be uploaded to the MCOs SharePoint site in the Annual Report Library in the folder [YR] HEDIS CAHPS APM. The APM report template is found at https://www.scdhhs.gov/resources/health-managed-care-plans/managed-care-organizations-mco/managed-care-resources

Exhibit 32- Annual Alternative Payment Models (APM) Report Requirements

ANNUAL APM REPORT				
Submission	Required Naming Convention	Required File Format	Notes	Due Date
APM	[PlanName]_APM CONTRACTING_RY [Two Digit Reporting Year].xls	XLS	Certification of the percentage of APM payments made to providers.	April 30th

APM	[PlanName]_APM CONTRACTING_RY [Two Digit Reporting Year].pdf	PDF	Certification of the percentage of APM payments made to providers. (Signed version)	April 30th

Alternative Payment Model Contracts

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 15.12

Corrective Action Plan

SCDHHS staff approves all of the MCO's Corrective Action Plan (CAP) and monitoring of disposition of identified items developed as a result of the annual external QA evaluation or any discrepancies found by the SCDHHS that require corrective actions. All Corrective Action Plan quarterly updates must be submitted to the MCO's SharePoint Required Submissions site and the MCO's Program liaison must be notified of the addition to the site.

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

Section 16.5

Historical Claims Reporting

The Department has a secure file transfer protocol (FTP) site for each MCO. The Department will load Medicaid FFS Claims to the MCO's FTP site for all Beneficiaries enrolled with the MCO each month.

MCO Contract APPENDIX F

BABYNET

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 in *Example 33*. 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 eligibility. This date is derived from date of birth and Individualized Family Service Plan information.

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 in *Exhibits 34-35*. 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.

Exhibit 33- BabyNet Members Report

PLAN_ID	PLAN_NAME	MID	DOB	PCAT	BNET_ START	BNET_ END	MCHM_ELIG	MCHM_INELIG	THERAPY_AUTH_F IRST_DOS	THERAPY_AUTH_L AST_DOS

Exhibit 34- 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

Exhibit 35- 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

Dual Special Needs (D-SNP) Program

Reporting Requirements

Integrated Managed Care Reports List

Highly Integrated Dual Eligible Special Needs Program (HIDE-SNP)

Where to submit reports: All reports should be submitted via an SCDHHS approved SFTP system. If the Contractor requires access or assistance with submitting reports, please contact the current SCDHHS D-SNP contract administrator. If by chance that a report must be submitted in a way that does not utilize the approved SFTP system, the Contractor shall coordinate with the SCDHHS D-SNP contract administrator to ensure that it submitted securely and in a way that protects PII/PHI.

When to submit reports: Reports are to be submitted in accordance with the timing structure laid out in the chart below and in the relevant section of the Highly Integrated Dual Eligible (HIDE) State Medicaid Agency Contract (SMAC).

Report Formatting: All Medicaid reports structure should be developed using the approved templates provided by SCDHHS. The formatting and structure of these templates are not to be edited or altered in any way, except to add rows to accommodate the submission of additional data if necessary. If there is no approved template for a required report such as organizational structure, the Contractor may choose the format that works best for them as long as that format adheres to all data fields or provisions defined in the HIDE SMAC.

*The reporting requirements cited below are found in each health plans SMAC, where applicable. *

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
Duals Administrative Reporting Requirements						
HIDE SMAC Section 9.2.1.5	Ops Report	General operative provisions and performance metrics	Monthly	The fifteenth (15th) Day of the following month	Contractor	SCDHHS
HIDE SMAC Section 9.2.1.4	Emergency Management Reporting	In the event of a state of emergency being declared; health plans are required to report to SCDHHS on the condition of their members. Health plans are required to utilize the emergency management reporting template provided by SCDHHS	Ad-Hoc	Weekly after declaration until lifted or otherwise advised by DHHS	Contractor	SCDHHS
HIDE SMAC Section 9.3.5	Proposed Changes to Covered Benefits Report	Informs SCDHHS when the health plan is proposing changes to its covered benefits	Annually	Within thirty (30) calendar days of submission to CMS	Contractor	SCDHHS
HIDE SMAC Section 9.2.1.4.2	Organizational Structure Report	Specific Format not defined. D-SNP can utilize any format it chooses to present the data. Must be submitted within 14 business days of change in personnel. organizational structure is limited to Administrator (COO, CEO, Executive Director, etc.), CFO, Contract Manager,	Annually or Ad-Hoc (When necessary)	The fifteenth (15th) of January or within two (2) weeks of a significant change	Contractor	SCDHHS

		Medical Director, Pharmacy Director, and Quality Improvement (QI) and/or Quality Management (QM) Coordinator, Manager, or Director				
HIDE SMAC Section 12.7	Fraud Reporting	D-SNP should send report when they suspect member or Provider fraud and abuse. There is no standardized reporting template for this item.	Ad-Hoc	Within 48 hours of discovery	Contractor	SCDHHS
Duals Operational Reporting Requirements						
HIDE SMAC Section 9.3.4	Enrollment Report	Details the total number of members within a health plan and relevant demographic information for each member	Monthly	The fifteenth (15th) Day of the following month	Contractor	SCDHHS
HIDE SMAC Section 9.2.1.1-9.2.1.2	Skilled Nursing Facility (SNF)/ In Patient Hospital Admissions Reporting	Informs SCDHHS when a “High-Risk” member is admitted to a SNF or other in-patient hospital facility	Ad-Hoc	Within 48 hours of Admission of a High-Risk patient	Contractor	SCDHHS
HIDE SMAC Section 9.2.1.2.1	Appeals and Grievances Reporting	Grievance and Appeal reporting required of the D-SNP	Monthly	Within 5 days of CMS submission	Contractor	SCDHHS
HIDE SMAC Section 9.2.1.2.2	Care Management Reporting	Report of members receiving care management services on an ongoing basis with the D-SNP	Monthly	Within 5 days of CMS submission	Contractor	SCDHHS

HIDE SMAC Section 9.1.1	HEDIS Reporting	Member satisfaction information. NCQA defined.	Annually	Within 5 days of CMS submission	Contractor	SCDHHS
HIDE SMAC Section 9.1.1	CAHPS	Member satisfaction information. NCQA defined. Submitted to both NCQA and SCDHHS.	Annually	Within 5 days of CMS submission	Contractor	SCDHHS
HIDE SMAC Section 9.4	Encounter Data	All member encounter data.	Daily, Weekly, Monthly	No later than thirty (30) calendar days from the end of the month	Contractor	SCDHHS
HIDE SMAC Section 9.1.1	Part C and Part D (CMS)	Part C Reporting: Part C Reporting Requirements | CMS Part D Reporting: Part D Reporting Requirements | CMS	Varying	Within 5 days of CMS submission	Contractor	SCDHHS

Integrated Managed Care Reports List

Coordination-Only Dual Special Needs Program (CO-DSNP)

Where to submit reports: All reports should be submitted via an SCDHHS approved SFTP system. If the Contractor requires access or assistance with submitting reports, please contact the current SCDHHS D-SNP contract administrator. If by chance that a report must be submitted in a way that does not utilize the approved SFTP system, the Contractor shall coordinate with the SCDHHS D-SNP contract administrator to ensure that it submitted securely and in a way that protects PII/PHI.

When to submit reports: Reports are to be submitted in accordance with the timing structure laid out in the chart below and in the relevant section of the Coordination-Only (CO) SMAC.

Report Formatting: All Medicaid reports structure should be developed using the approved templates provided by SCDHHS. The formatting and structure of these templates are not to be edited or altered in any way, except to add rows to accommodate the submission of additional data if necessary. If there is no approved template for a required report such as organizational structure, the Contractor may choose the format that works best for them as long as that format adheres to all data fields or provisions defined in the CO SMAC.

*The reporting requirements cited below are found in each health plans SMAC, where applicable. *

Section Reference	Managed Care Report Name	Description	Report Timing	Report Submission Due Date	Sender	Receiver
Duals Administrative Reporting Requirements						
CO SMAC Section 6.2.1.4	Ops Report	General operative provisions and performance metrics	Monthly	The fifteenth (15th) Day of the following month	Contractor	SCDHHS
CO SMAC Section 6.2.1.3	Emergency Management Reporting	In the event of a state of emergency being declared; health plans are required to report to SCDHHS on the condition of their members. Health plans are required to utilize the emergency management reporting template provided by SCDHHS	Ad-Hoc		Contractor	SCDHHS
CO SMAC Section 1.4	Proposed Changes to Covered Benefits Report	Informs SCDHHS when the health plan is proposing changes to its covered benefits	Annually	Within thirty (30) calendar days of submission to CMS	Contractor	SCDHHS
CO SMAC Section 6.2.1.3.2.1	Organizational Structure Report	Specific Format not defined. D-SNP can utilize any format it chooses to present the data. Must be submitted within 14 business days of change in personnel. organizational structure is limited to Administrator (COO, CEO, Executive Director, etc.), CFO, Contract Manager, Medical Director, Pharmacy Director, and Quality Improvement (QI) and/or Quality Management	Annually or Ad-Hoc (When necessary)	The fifteenth (15th) of January or within two (2) weeks of a significant change	Contractor	SCDHHS

		(QM) Coordinator, Manager, or Director				
CO SMAC Section 9.14	Fraud Reporting	D-SNP should send report when they suspect member or Provider fraud and abuse. There is no standardized reporting template for this item.	Ad-Hoc	Within 48 hours of discovery	Contractor	SCDHHS
Duals Operational Reporting Requirements						
CO SMAC Section 6.3.1	Enrollment Report	Details the total number of members within a health plan and relevant demographic information for each member	Monthly	The fifteenth (15th) Day of the following month	Contractor	SCDHHS
CO SMAC Section 6.2.1.1.1-6.2.1.1.2	Skilled Nursing Facility (SNF)/ In Patient Hospital Admissions Reporting	Informs SCDHHS when a "High-Risk" member is admitted to a SNF or other in-patient hospital facility	Ad-Hoc	Within 48 hours of Admission of a High-Risk patient	Contractor	SCDHHS
CO SMAC Section 6.2.1.2.1	Appeals and Grievances Reporting	Grievance and Appeal reporting required of the D-SNP	Monthly	Within 5 days of CMS submission	Contractor	SCDHHS
CO SMAC Section 6.2.1.2.2	Care Management Reporting	Report of members receiving care management services on an ongoing basis with the D-SNP	Monthly	Within 5 days of CMS submission	Contractor	SCDHHS
CO SMAC Section 6.2.2 & 6.1.2	HEDIS Reporting	Member satisfaction information. NCQA defined.	Annually	Within 5 days of CMS submission	Contractor	SCDHHS

CO SMAC Section 6.1.2	CAHPS	Member satisfaction information. NCQA defined. Submitted to both NCQA and SCDHHS.	Annually	Within 5 days of CMS submission	Contractor	SCDHHS
CO SMAC Section 6.4	Encounter Data	All member encounter data.	Daily, Weekly, Monthly	No later than thirty (30) calendar days from the end of the month	Contractor	SCDHHS
CO SMAC Section 6.1.2	Part C and Part D (CMS)	Part C Reporting: Part C Reporting Requirements | CMS Part D Reporting: Part D Reporting Requirements | CMS	Varying	Within 5 days of CMS submission	Contractor	SCDHHS

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:

i. 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).
ii. 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:

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

iii. 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 (30) 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 (10) 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 (30) 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 (60) 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 (6) 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 (5) business days of this event. The insurer shall also furnish the Director with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) 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 (5) 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 (5) 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 (30) 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 (5) 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 (5) 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 (5) 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 (60) 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 (10) 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 (2) 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 Reporting	1	N/A	N/A	8/1	Company	Y
	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:

****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 (15) 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 THE 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. HIPAA 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 CLAIMS HISTORY	2 to 3 business days after MGC cutoff. 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 277	Sent daily on all weekdays; excludes Saturday and Sunday. 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.
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.

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
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	
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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
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		
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.
Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
52.	Filler	1	144	144		
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.
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.
Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
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		
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		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
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.
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.
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.
Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
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.
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

Additional Instructions

- 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.
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.

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
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
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

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
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		
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.
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 (i.e. champus, highway).
61.	POLICY--LETTER-IND	1	718	718	C	If present, pass group address info.

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
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
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	

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
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		

Field Number	Field Name	Number of Bytes	Starting Location	Ending Location	N/ C	Description/Mask
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
   c. Unless otherwise specified, there will be no signed fields

Logic for Inclusion in this file

- 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

APPENDIX C

REPORTS CHARTS

Daily and As Necessary Report Requirements

Daily and As Necessary Reporting Requirements		
Managed Care Report Name	Description	Report Submission Date
Section 2		
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
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		
834 Report Layout	MCO receives these reports on a daily basis providing information on membership enrollment.	Daily
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
Section 4		
Universal PA	Required for providers requesting prior authorization (most) pharmaceuticals. Document can be found at https://msp.scdhhs.gov/managedcare/sitre-page/reference-tool	As Necessary
Universal Synagis PA	Required for providers requesting Synagis. Document can be found at https://msp.scdhhs.gov/managedcare/site-page/reference-tools	As Necessary

Additional Services Request Form	Required for requesting additional member services that an MCO would like to provide to encourage desired member outcomes.	As Necessary
Member Incentives	Required for requesting additional member health incentives that an MCO would like to provide to encourage desired member outcomes.	As Necessary
Section 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		
Premium Payment Adjustments	DHHS retroactive rate adjustment format to MCO PMPMs.	As Necessary
Section 11		
Provider Fraud Referral Form & Provider Waste and Abuse Referral Form	Form for reporting potential provider fraud and potential waste and abuse. Both forms are located on the Program Integrity SharePoint site.	As Necessary
Member Referral Form	Form for reporting potential member abuse and fraud issues that can be found on the Program Integrity SharePoint site.	As Necessary
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
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
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 Form	To request permission to conduct a targeted BEOMB run.	As Necessary
Section 12		
Marketing Materials	Copies of any marking materials the MCO will be using related to Medicaid services.	As Necessary
Marketing Activities Submission Log	Log MCOs use to notify DHHS of upcoming marketing activities.	As Necessary
Section 16		
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- Returned weekly to MCO

Monthly Report Requirements

Monthly Reporting Requirements		
Managed Care Report Name	Format	Report Timing
Section 2		
Key Personal Changes	Provides a list of Key Personnel changes including	Monthly
Section 3		
Eligibility Redetermination	Report produced for MCO's when a someone's is getting Medicaid eligibility redeterminations completed by SCDHHS.	Monthly
Call Center Performance	Call center performance metrics for Member English language line, Member Spanish language line, and Provider call center.	Monthly
Section 4		
High Cost No Experience (HCNE) Drug	Reimbursement for high cost no experience pharmaceuticals.	Monthly
Section 5		
Case Management Report	Report of all members receiving care management services on an ongoing basis with the MCO.	Monthly
Section 6		
Non-Par Template		Monthly
Section 7		
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 Report to be utilized 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; includes deceased members and duplicate member IDs.	Monthly
Patient Center Medical Home (PCMH) Assignments	MCO's submission is monthly, SCDHHS pays the MCO's on a quarterly basis. Utilized to reimburse	Monthly

	those primary care practices that qualify for this incentive payment.	
Section 10		
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
TPL Cost Avoidance	TPL cost avoidance report indicates those claims that the MCO has cost avoided during the month.	Monthly
TPL COB Savings	TPL Coordination of Benefits (COB) report indicates those claims leading to coordination of benefits savings for the MCO.	Monthly
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		
Termination Denial for Cause Report	MCO Monthly reporting of terminated providers that should be submitted directly to PI's SharePoint site.	Monthly
Section 13		
Claims Payment Accuracy	Report detailing monthly claim payment by the MCO.	Monthly
Psychiatric Residential Treatment Facility (PRTF)	Report detailing MCO members in or recently discharged from a PRTF.	Monthly
Section 14		
Encounter Submission Summary	Report detailing totals for monthly claims paid, accepted encounters, rejected encounters, and completeness percentage.	Monthly
Appendix E		
BabyNet Members	Report of members receiving BabyNet Services.	Monthly
BabyNet Providers	Report of BabyNet Providers	Monthly

Quarterly Reporting Requirements

Quarterly Reporting Requirements		
Managed Care Report Name	Format	Report Timing
Section 4		
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
Section 6		
Network Adequacy Report	Adequacy report sent to the MCOs within ten (10) business day of receipt from 3rd party vendor.	Quarterly
Provider Network Submission	MCO report sent to SCDHHS reflecting MCOs entire provider network.	Quarterly
Section 7		
MCO Withhold	Report template shared with the MCO to indicate quarterly withholding done to MCO's.	Quarterly
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
FQHC Wrap Payments	Current FQHC reports required for wrap payment process.	Quarterly, Annually
RHC Wrap Payments	Current RHC reports required for wrap payment process.	Quarterly, Annually
FQHC Prospective Payment System (PPS)	Reconciliation report or all FQHC payments within PPS.	Quarterly, Annually
Section 8		
Service Authorization Report	List of all service authorization requests including approval and denial reasons.	Quarterly, Annually
Section 9		

Member Grievance and Appeal Log	Grievance and Appeal reporting required of the MCO.	Quarterly, Annually
Provider Dispute Log	Provider dispute reporting required of the MCO.	Quarterly
Section 11		
MCO Quarterly Report	Quarterly reporting of fraud and abuse. This report should be submitted directly to Program Integrity's SharePoint site.	Quarterly
Section 13		
Graduate Medical Education (GME)	Report detailing payment for Graduate Medical Education Providers and Institutions.	Quarterly
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 extensions.	Quarterly, Annually
Section 14		
FQHC/RHC Encounter Reporting	Quarterly report of encounter claims data organized by data of service for all contracting FQHC & RHCs for the State Plan required for reconciliation purposes.	Quarterly
Encounter Quality Initiative (EQI)	Encounter Quality Initiative (EQUI) Report.	Quarterly, Annually
Section 15		
Quality Assessment & Performance Improvement Projects	Submitted quarterly to DEPARTMENT and annually to Constellation.	Quarterly, Annually

Bi-Annual and Annual Reporting Requirements

Semi-Annual and Annual Reporting Requirements		
Managed Care Report Name	Format	Report Timing
Section 1		
All CONTRACTOR Policies and Procedures	A full list of the CONTRACTOR's policies and procedures, including any policy and procedure updates.	Annually, As Necessary
Section 2		
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		
Institution for Mental Disease (IMD)	Report provided to MCOs of members 21-64 with an IMD stay exceeding 15 days.	Annually
Drug Utilization Review (DUR)	Annual drug utilization review for all pharmacy claims.	Annually
Expanded Benefit Chart	A list of the expanded benefits that different health plans offer beyond state covered services.	Annually
Additional Services Template	A comprehensive list of all Additional Services the plans offer along with descriptive information about each service.	Annually
Section 5		
Case Management Program Description	Description of CONTRACTOR's Case Management Program, including levels of case management description and determination.	Annually
Section 6		
Annual Network Development Plan	A detailed description of the MCO's provider network development plan to ensure provider network adequacy.	Annually
Section 7		

Medical Loss Ratio (MLR)	Medical Loss Ratio Calculation report indicating the proportion of premium revenues spent on clinical services and quality improvement.	Annually
Annual Rate Survey	DHHS sends out the Annual Rate Survey to the MCOs to complete and return to DHHS. Milliman uses this information to develop capitation rates for the coming state fiscal year.	Annually
FQHC Wrap Payments Annual	Current FQHC reports required for wrap payment process.	Annually, Quarterly
RHC Wrap Payments	Current RHC reports required for wrap payment process.	Annually, Quarterly
RQHC Prospective Payment System (PPS)	Reconciliation report for all FQHC payments with PPS amount.	Annually, Quarterly
Annual Audited Financial Statement	Should be the same report produced for the SC Department of Insurance.	Annually
Section 8		
Service Authorization Report	List of all service authorization requests including approval and denial reasons.	Annually, Quarterly
Section 9		
Member Grievance and Appeal Log	Grievance and Appeal reporting required of the MCO.	Annually, Quarterly
Section 11		
Annual Strategic Plan	Strategic Plan Matrix can be found at PI SharePoint site.	Annually
Written Compliance Plan	Annual Compliance Plan Matrix can be found at PI SharePoint site.	Annually
Section 13		
South Carolina Department of Insurance or National Association of Insurance Commissioners (SCDOI/NAIC)	Reports on financials that must be provided within five (5) working days after the SCDOI/NAIC due date plus extensions.	Annually, Quarterly
Section 14		
Encounter Quality Initiative (EQI)	Encounter Quality Initiative (EQI) Report.	Quarterly, Annually

Section 15		
Population Assessment Report	Copies of NCOA reports that are reviewed by the DEPARTMENT.	Annually
Quality Assessment & Performance Improvement Projects	Submitted quarterly to DEPARTMENT and annually to Constellation.	Annually, Quarterly
Healthcare Effectiveness Data and Information Set (HEDIS) Reporting	Member satisfaction information. NCQA defined.	Annually
Consumer Assessment of Healthcare Providers and System (CAHPS) Reporting	Member satisfaction information. NCQA defined. Submitted to both NCQA and SCDHHS.	Annually
Alternative Payment Models (APM) Contracting	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, Ad Hoc

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)

APPENDIX D

Network Adequacy Charts

The following guidelines are used in the review and approval of an MCO's Provider Networks. A full list of the Network Adequacy Service Groups and their data descriptions are outlined below. SCDHHS maintains the authority to make changes to these charts at any time.

Column Name	Definition	Additional Links
Subfile	Specifies specific details of a CPT/HCPCS. Found in the Medicaid Management Information System (MMIS) Table 6.	Medicaid Management Information System (MMIS) Table
Medicaid Provider Type	Place in which provider works. Found in the Medicaid Management Information System (MMIS) Table 09.	Medicaid Management Information System (MMIS) Table
Bill Type (Institutional Claim Types Only)	This is utilized to create a three-digit code used to indicate what type of bill is being filed from an institutional level. Found in the Medicaid Management Information System (MMIS) Table 7Z.	Medicaid Management Information System (MMIS) Table
Taxonomy Code	A taxonomy code is a unique, standardized 10-character alphanumeric code used to identify the type, classification, and area of specialization of a healthcare provider or organization.	
Taxonomy Description	Description of taxonomy codes classification and description.	
Practice Specialty	Provider licensure/ specialty field. Found in the Medicaid Management Information System (MMIS) Table 10.	Medicaid Management Information System (MMIS) Table
Pricing Specialty	Provider licensure/ specialty field. Found in the Medicaid Management Information System (MMIS) Table 10.	Medicaid Management Information System (MMIS) Table
Medicaid Service Grouping	A collection of services that are related or share a common characteristic, allowing for logical organization and management.	
Contract Status	1=Must be in network (Distance and drive time and contract access requirements apply) 2=Must be in network (Contract access requirements apply; distance and drive time requirements do not apply) 3=Attestation (Contracting with provider's not required but must meet member needs for service) 4= Service provision and contracting not required (additional services non core managed care services)	

Service Groups Facilities Providers

Network Adequacy Chart Service Groups Facility Providers							
Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Code	Taxonomy Description	Practice/ Pricing Specialty	Medicaid Service Grouping	Contract Status
	00	21,22,23,28, 65,66	314000000X	Skilled Nursing Facility		Nursing Home	2
	01	11,12,18,32,41,81,82, 84,86	322D00000X	Residential Treatment Facility-Emotionally Disturbed Children		Psychiatric Residential Treatment Facility	2
	01	11,12,18,32,41,81,82, 84,87	323P00000X	Psychiatric Residential Treatment Facility		Psychiatric Residential Treatment Facility	2
	01	11,12,18,32,41, 81,82, 84,86	261Q00000X	Clinic/Center		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,87	273R00000X	General Acute Care Hospital-Psychiatric Unit		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,89	273Y00000X	General Acute Care Hospital-Rehabilitation Unit		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,91	281PC2000X	Chronic Disease Hospital-Children		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,92	282E00000X	Long Term Care Hospital		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,93	282N00000X	General Acute Care Hospital		Inpatient Hospital	1

Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Code	Taxonomy Description	Practice/ Pricing Specialty	Medicaid Service Grouping	Contract Status
	01	11,12,18,32,41, 81,82, 84,95	282NC0060X	General Acute Care Hospital-Critical Access		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,96	282NC2000X	General Acute Care Hospital-Children		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,97	282NR1301X	General Acute Care Hospital-Rural		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,98	282NW0100X	General Acute Care Hospital-Women		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,99	283Q00000X	Psychiatric Hospital		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,100	283XC2000X	Rehabilitation Hospital-Children		Inpatient Hospital	1
	01	11,12,18,32,41, 81,82, 84,101	284300000X	Specialized Hospital		Inpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,89	261Q00000X	Clinic/Center	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,90	273R00000X	General Acute Care Hospital-Psychiatric Unit	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,91	273Y00000X	General Acute Care Hospital-Rehabilitation Unit	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,92	281PC2000X	Chronic Disease Hospital-Children	80	Outpatient Hospital	1

Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Code	Taxonomy Description	Practice/ Pricing Specialty	Medicaid Service Grouping	Contract Status
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,93	282E00000X	Long Term Care Hospital	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,94	282N00000X	General Acute Care Hospital	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,95	282NC0060X	General Acute Care Hospital-Critical Access	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,96	282NC2000X	General Acute Care Hospital-Children	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,97	282NR1301X	General Acute Care Hospital-Rural	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,98	282NW0100X	General Acute Care Hospital-Women	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,99	283Q00000X	Psychiatric Hospital	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,100	283XC2000X	Rehabilitation Hospital-Children	80	Outpatient Hospital	1
O	02	13,14,33,34,43,71,72,73,74,75,76,77, 79,83,85,101	284300000X	Specialized Hospital	80	Outpatient Hospital	1

Service Groups Ancillary & Professional Providers

Network Adequacy Chart Service Groups Ancillary and Professional							
Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	207K00000X	Allergy and Immunology	2	54	Allergy and Immunology	2
P	20	207KA0200X	Allergy and Immunology, Allergy	2	54	Allergy and Immunology	2
P	20	207KI0005X	Allergy and Immunology, Clinical and Laboratory Immunology	2	54	Allergy and Immunology	2
P	20	207RA0201X	Internal Medicine, Allergy and Immunology	19	14, AC	Allergy and Immunology	2
P	20	207RI0001X	Internal Medicine, Clinical & laboratory Immunology	19	14, AC	Allergy and Immunology	2
T	22	261QM2500X	Ambulatory Health Care Facility, Medical Specialty	93	93	Ambulatory Centers	2
T	22	261Q00000X	Ambulatory Health Care Facility, Clinic	93	93	Ambulatory Centers	2
T	22	261QM1300X	Ambulatory Health Care Facilities/Clinic/Center	93	93	Ambulatory Centers	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
N/A	22	261QR0401X	Ambulatory Health Care Facility, Comprehensive Outpatient Rehabilitation Facility	N/A	N/A	Ambulatory Centers	2
N/A	22	261QR0400X	Ambulatory Health Care Facility, Rehabilitation Facility	N/A	N/A	Ambulatory Centers	2
N/A	22	261QF0050X	Ambulatory Health Care Facilities/Family Planning	N/A	N/A	Ambulatory Centers	2
K	22	261QB0400X	Ambulatory Health Care Facilities/Clinic/Birthing Center	6	6	Ambulatory Centers	2
V	22	261QD1600X	Ambulatory Care Facility- Developmental Disabilities	95	95	Ambulatory Centers	2
V	22	261QG0250X	Ambulatory Care Facility- Genetics	95	95	Ambulatory Centers	2
V	22	261QH0700X	Ambulatory Health Care Facility, Hearing and Speech	95	95	Ambulatory Centers	2
V	22	261QS0132X	Ambulatory Health Care Facilities/ Ophthalmologic Surgery	95	95	Ambulatory Centers	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
V	22	261QI0500X	Ambulatory Health Care Facilities/Clinic/Center-Infusion Therapy	95	95	Ambulatory Centers	2
T	22	261QA1903X	Ambulatory Surgical Center	93	93	Ambulatory Centers	2
T	22	261QE0800X	Ambulatory Surgical Center	93	93	Ambulatory Centers	2
L	20	207L00000X	Anesthesiology	3	3	Anesthesiology	3
L	20	207LC0200X	Anesthesiology, Critical Care Medicine	3	3	Anesthesiology	3
L	20	207LP3000X	Anesthesiology, Pediatric	03, AA	03, AA	Anesthesiology	3
L	19	367500000X	Advanced Practice Nursing Provider/Nurse Anesthetist	25	25	Anesthesiology	3
B	19	103K00000X	Behavioral Analyst	BA	BA	Autism	1
B	19	106E00000X	Assistant Behavioral Analyst	BB	BB	Autism	1
P	20	207RC0000X	Cardiovascular Disease	5	54	Cardiology	1
P	20	207RC0001X	Internal Medicine, Cardiac Electrophysiology	19	14, AC	Cardiology	1
P	20	207RI0011X	Internal Medicine, Interventional Cardiology	19	14, AC	Cardiology	1
E	10	251B00000X	Case Management	20	20	Case Management	4

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
E	10	171M00000X	Case Management	20	20	Case Management	4
Y	37	111N00000X	Chiropractor	7	54	Chiropractor	2
Y	37	111NI0013X	Chiropractor, Independent Medical Examiner	7	54	Chiropractor	2
Y	37	111NI0900X	Chiropractor, Internist	7	54	Chiropractor	2
Y	37	111NN0400X	Chiropractor, Neurology	7	54	Chiropractor	2
Y	37	111NN1001X	Chiropractor, Nutrition	7	54	Chiropractor	2
Y	37	111NX0100X	Chiropractor, Occupational Medicine	7	54	Chiropractor	2
Y	37	111NX0800X	Chiropractor, Orthopedic	7	54	Chiropractor	2
Y	37	111NP0017X	Chiropractor, Pediatric Chiropractor	7	54	Chiropractor	2
Y	37	111NR0200X	Chiropractor, Radiology	7	54	Chiropractor	2
Y	37	111NR0400X	Chiropractor, Rehabilitation	7	54	Chiropractor	2
Y	37	111NS0005X	Chiropractor, Sport Physician	7	54	Chiropractor	2
Y	37	111NT0100X	Chiropractor, Thermography	7	54	Chiropractor	2
P	20	208C00000X	Surgeon, Colon & Rectal	62	54	Colon and Rectal Surgery	2
F	10	261QM0850X	Adult Mental Health	28	28	Community Mental Health	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
F	10	261QM0855X	Adolescent and Children Mental Health	28	28	Community Mental Health	2
F	10	261QM0801X	Mental Health Including Community Mental Health Center	28	28	Community Mental Health	2
A	30	1223S0112X	Oral and Maxillofacial Surgery (Dentist)	08, 35, 43	72	Dental	4
A	30	12230000X	Dentist	08, 35, 43	72	Dental	4
A	30	1223D0001X	Dental Public Health	08, 35, 43	72	Dental	4
A	30	1223D0004X	Dental Anesthesiologist	08, 35, 43	72	Dental	4
A	30	1223E0200X	Endodontics	08, 35, 43	72	Dental	4
A	30	1223G0000X	General Practice	08, 35, 43	72	Dental	4
A	30	1223P0106X	Oral and Maxillofacial Pathology	08, 35, 43	72	Dental	4
A	30	1223X0008X	Oral and Maxillofacial Radiology	08, 35, 43	72	Dental	4
A	30	1223X0400X	Orthodontics and Dentofacial Orthopedics	08, 35, 43	72	Dental	4
A	30	1223P0221X	Pediatric Dentistry	08, 35, 43	72	Dental	4
A	30	1223P0300X	Periodontics	08, 35, 43	72	Dental	4

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
A	30	1223P0700X	Prosthodontics	08, 35, 43	72	Dental	4
A	30	204E00000X	Surgeon, Oral & Maxillofacial	63	54	Dental	4
P	20	207N00000X	Dermatology	9	54	Dermatology	2
P	20	207N10002X	Dermatology, Clinical and Lab Dermatological Immunology	9	54	Dermatology	2
P	20	207ND0101X	Dermatology, MOHS-Micrographic Surgery	09	54	Dermatology	2
P	20	207ND0900X	Dermatology, Dermatopathology	9	54	Dermatology	2
P	20	2081P0010X	Allopathic & Osteopathic Physicians/Dermatology, Clinical & Laboratory Dermatological Immunology	09	54	Dermatology	2
P	20	207NS0135X	Dermatology, Procedural	9	54	Dermatology	2
R	22	251K00000X	Agencies Public Health	51	51	DHEC	2
K	19	133V00000X	Registered Dietician	DT	DT	Dietician/Nutrition	2
K	19	133VN1006X	Registered Dietician, Nutrition, Metabolic	DT	DT	Dietician/Nutrition	2
K	19	133VN1004X	Dietician, Pediatric	DT	DT	Dietician/Nutrition	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
K	19	133VN1005X	Dietician, Renal	DT	DT	Dietician/Nutrition	2
U	22	163WD0400X	Diabetes Educator	94	94	Dietician/Nutrition	2
U	22	133NN1002X	Nutrition, Education	94	94	Dietician/Nutrition	2
Y	76	332BP3500X	Parenteral and Enteral Nutrition	N/A	59	Durable Medical Equipment	2
Y	76	332S00000X	Hearing Aid Equipment Supplier	N/A	59	Durable Medical Equipment	2
Y	76	332BX2000X	Supplier, Oxygen Equipment & Supplies	N/A	59	Durable Medical Equipment	2
Y	76	332B00000X	Supplier, DME & Medical Supplies	N/A	59	Durable Medical Equipment	2
P	20	207P00000X	Emergency Medicine	10	54	Emergency Medicine	3
P	20	207PE0004X	Emergency Medicine, Emergency Medical Services	10	54	Emergency Medicine	3
P	20	207PH0002X	Emergency Medicine, Hospice and Palliative Medicine	10	54	Emergency Medicine	3
P	20	207PT0002X	Emergency Medicine, Medical Toxicology	10	54	Emergency Medicine	3
P	20	207PS0010X	Emergency Medicine, Sports Medicine	10	54	Emergency Medicine	3
P	20	207PE0005X	Emergency Medicine, Under sea & Hyperbaric	10	54	Emergency Medicine	3

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	207RE0101X	Internal Medicine, Endocrinology Diabetes & Metabolism	19	14, AC	Endocrinology	2
P	20	2083P0500X	Physician, Environmental Medicine		54	Environmental Medicine	3
Q	22	261QE0700X	End Stage Renal Disease	21	54	ESRD Clinic	3
P	20	207RG0100X	Gastroenterology	13	54	Gastroenterology	1
P	20	207RG0001X	Internal Medicine, Gastroenterology	19	54	Gastroenterology	1
P	20	207RB0002X	Internal Medicine, Bariatric Medicine	19	14, AC	Gastroenterology	1
P	20	208600000X	Surgeon	63	54	General Surgery	1
P	20	2086H0002X	Surgeon, Hospice and Palliative	63	54	General Surgery	1
P	20	2086S0102X	Surgery Critical Care	63	54	General Surgery	1
P	20	208600102X	Surgeon, Critical Care	63	54	General Surgery	1
P	20	2086S0127X	Surgeon, Trauma Surgery	63	54	General Surgery	1
P	20	207SC0300X	Allopathic & Osteopathic Physicians/Clinical Cytogenetic	19	14	Genetics	3
P	20	207SG0201X	Clinical Genetics	19	14	Genetics	3
P	20	207RH0003X	Hematology & Oncology	17, 30	54	Hematology and Oncology	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	207RH0000X	Internal Medicine, Hematology	19	14, AC	Hematology and Oncology	1
P	20	207RX0202X	Internal Medicine, Medical Oncology	19	14, AC	Hematology and Oncology	1
1-9, $	61	y Atypical		N/A	77	Home and Community Based Services	4
D	60	251E00000X	Home Health	N/A	0	Home Health	2
D	60	251G00000X	Hospice Care, Community Based	N/A	0	Hospice	4
P	20	208M00000X	Hospitalist	19	14	Hospitalist	3
P	20	207RI0200X	Internal Medicine, Infectious Disease	19	14, AC	Infectious Disease	2
Y	80	291U00000X	Clinical Medical Laboratory	N/A	54	Laboratory/X-ray	2
Y	80	291900000X	Military Clinical Medical Laboratory	N/A	54	Laboratory/X-ray	2
Y	81	335V00000X	Portable X-Ray Supplier	N/A	54	Laboratory/X-ray	2
Y	81	293D00000X	Laboratory Physiological Laboratory	N/A	54	Laboratory/X-ray	2
Y	81	261QM1200X	Ambulatory Care Facility-Magnetic Resonance Imaging	N/A	54	Laboratory/X-ray	2
Y	81	261QR0206X	Ambulatory Health Care Facilities/Clinic-Center, Radiology, Mammography	N/A	54	Laboratory/X-ray	2
Y	81	261QR0208X	Radiology, Mammography	N/A	54	Laboratory/X-ray	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
Y	81	261QR0207X	Radiology, Mobile Mammography	N/A	54	Laboratory/X-ray	2
Y	81	261QR0200X	Imaging Facility	N/A	54	Laboratory/X-ray	2
Y	81	2471M1202X	Magnetic Resonance Imaging	N/A	54	Laboratory/X-ray	2
Y	81	261QS1200X	Sleep Disorder Diagnostic	N/A	54	Laboratory/X-ray	2
M	19	101Y00000X	Counselor Behavioral Health	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW	Licensed Mental Health Professionals	1
M	19	1041C0700X	Behavioral Health & Social Service Providers/Social Workers	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW	Licensed Mental Health Professionals	1
M	19	106H00000X	Behavioral Health & Social Service Providers/Marriage and Family Therapy	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW	Licensed Mental Health Professionals	1
M	19	101YP1600X	Counselor- Pastoral	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW	Licensed Mental Health Professionals	1
M	19	101YS0200X	Counselor- School	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW	Licensed Mental Health Professionals	1
M	19	101YM0800X	Behavioral Health & Social Service Providers/Mental Health	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW	Licensed Mental Health Professionals	1
M	19	104100000X	Social Worker	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW	Licensed Mental Health Professionals	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
M	19	101YP2500X	Professional Behavioral Health & Social Service Providers/Social Workers	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW	Licensed Mental Health Professionals	1
P	20	202C00000X	Allopathic & Osteopathic Physicians/Independent Medical Examiner		54	Medical Examiner	3
Y	82	341600000X	Ambulance	N/A	0	Medical Transportation	3
Y	82	3416A0800X	Ambulance, Air Transport	N/A	0	Medical Transportation	3
Y	82	3416L0300X	Ambulance, Land Transport	N/A	0	Medical Transportation	3
Y	82	3416S0300X	Ambulance, Water Transport	N/A	0	Medical Transportation	3
D	84	341600000X	Ambulance	N/A	0	Medical Transportation	3
D	84	3416A0800X	Ambulance, Air Transport	N/A	0	Medical Transportation	3
D	84	3416L0300X	Ambulance, Land Transport	N/A	0	Medical Transportation	3
D	84	3416S0300X	Ambulance, Water Transport	N/A	0	Medical Transportation	3
K	19	175M00000X	Lay Midwife	6	6	Midwife	3
K	19	176B00000X	Nurse Midwife	6	6	Midwife	3
K	19	367A00000X	Advanced Practice Nursing Provider/Certified Nurse Midwife	6	6	Midwife	3

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	207RN0300X	Internal Medicine, Nephrology	19	14, AC	Nephrology	1
P	20	2084P2900X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Neurodevelopmental	22	54	Neurology	1
P	20	2084A0401X	Psychiatry & Neurology, Addiction Medicine	48	54	Neurology	1
P	20	2084N0600X	Allopathic & Osteopathic Physicians/Neurophysiology	48	54	Neurology	1
P	20	2088F0040X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Vascular Neurology	22	54	Neurology	1
K	19	363L00000X	Nurse Practitioner	86	86	Nurse Practitioner	2
K	19	363LA2100X	Nurse Practitioner, Acute Care	86	86	Nurse Practitioner	2
K	19	363LA2200X	Nurse Practitioner, Adult Health	86	86	Nurse Practitioner	2
K	19	363LC1500X	Nurse Practitioner, Community Health	86	86	Nurse Practitioner	2
K	19	363LC0200X	Nurse Practitioner, Critical Care Medicine	86	86	Nurse Practitioner	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
K	19	363LF0000X	Nurse Practitioner, Family	86	86	Nurse Practitioner	2
K	19	363LG0000X	Nurse Practitioner, Gerontology	86	86	Nurse Practitioner	2
K	19	363LN0000X	Nurse Practitioner, Neonatal	86	86	Nurse Practitioner	2
K	19	363LN0005X	Nurse Practitioner, Neonatal Critical Care	86	86	Nurse Practitioner	2
K	19	363LX0001X	Nurse Practitioner, Obstetrics & Gerontology	86	86	Nurse Practitioner	2
K	19	363LX0106X	Nurse Practitioner, Occupational Health	86	86	Nurse Practitioner	2
K	19	363LP0200X	Nurse Practitioner, Pediatrics	86	86	Nurse Practitioner	2
K	19	363LP0222X	Nurse Practitioner, Pediatrics Critical Care	86	86	Nurse Practitioner	2
K	19	363LP1700X	Nurse Practitioner, Perinatal	86	86	Nurse Practitioner	2
K	19	363LP2300X	Nurse Practitioner, Primary Care	86	86	Nurse Practitioner	2
K	19	363LP0808X	Nurse Practitioner, Psychiatric	86	86	Nurse Practitioner	2
K	19	363LS0200X	Nurse Practitioner, School	86	86	Nurse Practitioner	2
K	19	363LW0102X	Nurse Practitioner, Women's Health	86	86	Nurse Practitioner	2
P	20	207VX0000X	Obstetrics and Gynecology, Obstetrics	26	14, AC	OB/GYN	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	207VE0102X	Obstetrics and Gynecology, Reproductive Endocrinology	27	14, AC	OB/GYN	1
P	20	207V00000X	Obstetrics and Gynecology	27	14, AC	OB/GYN	1
P	20	207VB0002X	Obstetrics and Gynecology, Bariatric	27	14, AC	OB/GYN	1
P	20	207VC0200X	Obstetrics and Gynecology, Critical Care	27	14, AC	OB/GYN	1
P	20	207VX0201X	Obstetrics and Gynecology, Gynecologic Oncology	27	14, AC	OB/GYN	1
P	20	207VG0400X	Obstetrics and Gynecology, Gynecology	27	14, AC	OB/GYN	1
P	20	207VH0002X	Obstetrics and Gynecology, Hospice and Palliative Care	27	14, AC	OB/GYN	1
P	20	207VM0101X	Obstetrics and Gynecology, Maternal and Fetal Medicine	27	14, AC	OB/GYN	1
N	19	225X00000X	Occupational Therapist	87	84	Occupational Therapy	1
N	19	225XR0403X	Occupational Therapist, Driving & Community Mobility	87	84	Occupational Therapy	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
N	19	225XE0001X	Occupational Therapist, Environmental Modification	87	84	Occupational Therapy	1
N	19	225XE1200X	Occupational Therapist, Ergonomics	87	84	Occupational Therapy	1
N	19	225XF0002X	Occupational Therapist, Feeding, Eating, Swallowing	87	84	Occupational Therapy	1
N	19	225XG0600X	Occupational Therapist, Gerontology	87	84	Occupational Therapy	1
N	19	225XH1200X	Occupational Therapist, Hand	87	84	Occupational Therapy	1
N	19	225XH1300X	Occupational Therapist, Human Factors	87	84	Occupational Therapy	1
N	19	225XL0004X	Occupational Therapist, Low Vision	87	84	Occupational Therapy	1
N	19	225XM0800X	Occupational Therapist, Mental Health	87	84	Occupational Therapy	1
N	19	225XN1300X	Occupational Therapist, neurorehabilitation	87	84	Occupational Therapy	1
N	19	225XP0200X	Occupational Therapist, Pediatrics	87	84	Occupational Therapy	1
N	19	225XP0019X	Occupational Therapist, Physical Rehabilitation	87	84	Occupational Therapy	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
X	32	156FX1800X	Optician	33	33	Optometry	1
X	33	152W00000X	Optometrist	34	72	Optometry	1
X	33	152WC0802X	Optometrist, Corneal and Contact Management	34	72	Optometry	1
X	33	152WL0500X	Optometrist, Low Vision Rehabilitation	34	72	Optometry	1
X	33	152WX0102X	Optometrist, Occupational Vision	34	72	Optometry	1
X	33	152WP0200X	Optometrist, Pediatrics	34	72	Optometry	1
X	33	152WS0006X	Optometrist, Sports Vision	34	72	Optometry	1
X	33	152WV0400X	Optometrist, Vision Therapy	34	72	Optometry	1
P	20	207WX0200X	Allopathic & Osteopathic Physicians/Ophthalmic Plastic and Reconstructive Surgery	31	54	Optometry	1
P	20	207WX0009X	Allopathic & Osteopathic Physicians/Glaucoma Specialist	31	54	Optometry	1
P	20	207WX0107X	Allopathic & Osteopathic Physicians/Retina Specialist	31	54	Optometry	1
P	20	207W00000X	Ophthalmology	31	54	Optometry	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	208600105X	Surgeon, Hand Surgery	63	54	Orthopedic Surgery	2
P	20	207XX0801X	Surgeon, Orthopedic Trauma	67	54	Orthopedic Surgery	2
P	20	207X00000X	Surgeon, Orthopedic Surgery	67	54	Orthopedic Surgery	2
P	20	207XS0117X	Surgeon, Orthopedic Surgery of Spine	67	54	Orthopedic Surgery	2
P	20	207XS0114X	Surgeon, Adult Reconstructive Orthopedic Surgery	67	54	Orthopedic Surgery	2
P	20	207XX0004X	Surgeon, Foot and Ankle	67	54	Orthopedic Surgery	2
P	20	207XS0106X	Surgeon, Hand	63	54	Orthopedic Surgery	2
P	20	2086S0105X	Surgery, Surgery of the hand	69	54	Orthopedic Surgery	2
P	20	207XX0005X	Surgeon, Sports Medicine	63	54	Orthopedic Surgery	2
Y	76	222Z00000X	Orthotist	N/A	59	Orthotics/Prosthetics	2
Y	76	224P00000X	Prosthetist	N/A	59	Orthotics/Prosthetics	2
Y	76	332BC3200X	Supplier, Prosthetics & Orthotics	N/A	59	Orthotics/Prosthetics	2
Y	76	335E00000X	Supplier, Prosthetics & Orthotics	N/A	59	Orthotics/Prosthetics	2
P	20	207Y00000X	Otolaryngology	36	54	Otolaryngology/ Otorhinolaryngology	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	207YS0123X	Otolaryngology, Facial Plastic Surgery	36, 69	54	Otolaryngology/ Otorhinolaryngology	1
P	20	207YX0602X	Otolaryngology, Otolaryngic Allergy	36	54	Otolaryngology/ Otorhinolaryngology	1
P	20	207YX0905X	Otolaryngology, Otolaryngology/Facial Plastic surgery	36, 69	54	Otolaryngology/ Otorhinolaryngology	1
P	20	207YX0901X	Otolaryngology, Otology & neurotology	36	54	Otolaryngology/ Otorhinolaryngology	1
P	20	207YP0228X	Otolaryngology, Pediatric	AA	AA	Otolaryngology/ Otorhinolaryngology	1
P	20	207YX0007X	Otolaryngology, Plastic Surgery Head & Neck	36, 69		Otolaryngology/ Otorhinolaryngology	1
P	20	207YS0012X	Otolaryngology, Sleep Medicine	36		Otolaryngology/ Otorhinolaryngology	1
P	20	207RH0002X	Internal Medicine, Hospice & palliative care	19	14, AC	Pain Medicine	2
P	20	208VP0014X	Pain Medicine, Interventional Pain Medicine	03, 14, 54	03, 14, 54	Pain Medicine	2
P	20	2084V0102X	Allopathic & Osteopathic Physicians/ Psychiatry & Neurology, Pain Medicine	22, 48	54	Pain Medicine	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	2081P2900X	Pain Medicine, Interventional Pain Medicine	03, 14, 54	03, 14, 54	Pain Medicine	2
P	20	208VP0000X	Physicians, Pain Management	03, 14, 54	03, 14, 54	Pain Medicine	2
P	20	207LH0002X	Anesthesiology, Hospice and Palliative Care	03, 14, 54	03, 14, 54	Pain Medicine	2
P	20	207LP2900X	Anesthesiology, Pain Medicine	03, 14, 54	03, 14, 54	Pain Medicine	2
P	20	207ZB0001X	Pathology, Blood Banking & Transfusion Medicine	38	54	Pathology	3
P	20	207ZP0104X	Pathology, Chemical Pathology	38	54	Pathology	3
P	20	207ZC0006X	Pathology, Clinical Pathology	39	54	Pathology	3
P	20	207ZP0105X	Pathology, Clinical Pathology/Laboratory	39	54	Pathology	3
P	20	207ZC0500X	Pathology, Cytopathology	38	54	Pathology	3
P	20	207ZD0900X	Pathology, Dermatopathology	38	54	Pathology	3
P	20	207ZF0201X	Pathology, Forensic Pathology	38	54	Pathology	3
P	20	207ZH0000X	Pathology, Hematology	38	54	Pathology	3
P	20	207ZP0101X	Anatomic Pathology	38	54	Pathology	3
P	20	207ZI0100X	Pathology, Immunopathology	38	54	Pathology	3

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	207ZM0300X	Pathology, Medical Microbiology	38	54	Pathology	3
P	20	207ZP0007X	Pathology, Molecular Genetic Pathology	38	54	Pathology	3
P	20	207ZN0500X	Pathology, Neuropathology	38	54	Pathology	3
P	20	207ZP0213X	Pathology, Pediatric Pathology	AA	AA	Pathology	3
P	20	207ZP0102X	Anatomic Pathology & Clinical Pathology	38	54	Pathology	3
P	20	2080A0000X	Pediatrics, Adolescent	40	14, AC	Pediatrics	1
P	20	208000000X	Pediatrics	40	14, AC	Pediatrics	1
	20	207RA0000X	Internal Medicine, Adolescent Medicine	19	14, AC	Pediatrics	1
P	20	2080I0007X	Pediatrics, Clinical & Laboratory Immunology	AA	AA	Pediatric Subspecialists	1
P	20	2080P0006X	Pediatrics, Developmental Behavioral	AA	AA	Pediatric Subspecialists	1
P	20	2080C0008X	Allopathic & Osteopathic Physicians/Pediatrics, Child Abuse Pediatrics	AA	AA	Pediatric Subspecialists	1
P	20	2080H0002X	Pediatrics, Hospice and Palliative	AA	AA	Pediatric Subspecialists	1
P	20	2080T0002X	Pediatrics, Medical Toxicology	AA	AA	Pediatric Subspecialists	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	2080N0001X	Pediatrics, Neonatal-Perinatal	AA	AA	Pediatric Subspecialists	1
P	20	2080P0008X	Pediatrics, Neurodevelopmental Disabilities	AA	AA	Pediatric Subspecialists	1
P	20	2080P0201X	Pediatrics, Allergy and Immunology	AA	AA	Pediatric Subspecialists	1
	20	207NP0225X	Dermatology, Pediatric	AA	AA	Pediatric Subspecialists	1
P	20	2080P0202X	Pediatrics, Cardiology	AA	AA	Pediatric Subspecialists	1
P	20	2080P0203X	Pediatrics, Critical Care	AA	AA	Pediatric Subspecialists	1
P	20	2080P0204X	Pediatrics, Emergency Medicine	AA	AA	Pediatric Subspecialists	1
P	20	2080P0205X	Pediatrics, Endocrinology	AA	AA	Pediatric Subspecialists	1
P	20	2080P0206X	Pediatrics, Gastroenterology	AA	AA	Pediatric Subspecialists	1
P	20	207PP0204X	Emergency Medicine, Pediatric	AA	AA	Pediatric Subspecialists	1
P	20	2080P0208X	Pediatrics, Infectious Disease	AA	AA	Pediatric Subspecialists	1
P	20	2080P0207X	Pediatrics, Hematology Oncology	AA	AA	Pediatric Subspecialists	1
P	20	2080P0210X	Pediatrics, Nephrology	AA	AA	Pediatric Subspecialists	1
P	20	2080P0214X	Pediatrics, Pulmonology	AA	AA	Pediatric Subspecialists	1
P	20	2080P0216X	Pediatrics, Rheumatology	AA	AA	Pediatric Subspecialists	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	2080T0004X	Pediatrics, Transplant Hepatology	AA	AA	Pediatric Subspecialists	1
P	20	2080S0012X	Pediatrics, Sleep Medicine	AA	AA	Pediatric Subspecialists	1
P	20	2080S0010X	Pediatrics, Sports Medicine	AA	AA	Pediatric Subspecialists	1
P	20	2083P0901X	Allopathic & Osteopathic Physicians/Physical Medicine & Rehabilitation, Pediatric Rehabilitation Medicine	AA	AA	Pediatric Subspecialists	1
P	20	2088P0231X	Allopathic & Osteopathic Physicians/Urology, Pediatric Urology	AA	AA	Pediatric Subspecialists	1
P	20	207XP3100X	Surgeon, Pediatric Orthopedic Surgery	AA	54	Pediatric Subspecialists	1
P	20	2085R0204X	Pediatric Radiology	AA	AA	Pediatric Subspecialists	1
P	20	2086S0120X	Surgeon, Pediatric	AA	AA	Pediatric Subspecialists	1
N/A	70	333600000X	Supplier, Pharmacy	N/A	N/A	Pharmaceutical Services	2
N/A	70	3336C0002X	Supplier, Pharmacy Clinic	N/A	N/A	Pharmaceutical Services	2
N/A	70	3336C0003X	Supplier, Retail Pharmacy	N/A	N/A	Pharmaceutical Services	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
N/A	70	3336C0004X	Supplier, Compounding Pharmacy	N/A	N/A	Pharmaceutical Services	2
N/A	70	3336H0001X	Supplier, Home Infusion Therapy Pharmacy	N/A	N/A	Pharmaceutical Services	2
N/A	70	3336I0012X	Supplier, Institutional Pharmacy	N/A	N/A	Pharmaceutical Services	2
N/A	70	3336L0003X	Supplier, Long Term Care Pharmacy	N/A	N/A	Pharmaceutical Services	2
N/A	70	3336M0002X	Supplier, Mail Order Pharmacy	N/A	N/A	Pharmaceutical Services	2
N/A	70	3336M0003X	Supplier, Managed Care Organization Pharmacy	N/A	N/A	Pharmaceutical Services	2
N/A	70	3336N0007X	Supplier, Nuclear Pharmacy	N/A	N/A	Pharmaceutical Services	2
N/A	70	3336S0011X	Supplier, Specialty Pharmacy	N/A	N/A	Pharmaceutical Services	2
P	20	202K00000X	Allopathic & Osteopathic Physicians/ Phlebology		54	Phlebology	3
N	19	225100000X	Physical Therapist	85	84	Physical Therapy	1
N	19	2251C2600X	Physical Therapist, Cardiopulmonary	85	84	Physical Therapy	1
N	19	2251E1300X	Physical Therapist, Electrophysiology	85	84	Physical Therapy	1
N	19	2251E1200X	Physical Therapist, Ergonomics	85	84	Physical Therapy	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
N	19	2251G0304X	Physical Therapist, Geriatrics	85	84	Physical Therapy	1
N	19	2251H1200X	Physical Therapist, Hand	85	84	Physical Therapy	1
N	19	2251H1300X	Physical Therapist, Human Factors	85	84	Physical Therapy	1
N	19	2251N0400X	Physical Therapist, Neurology	85	84	Physical Therapy	1
N	19	2251X0800X	Physical Therapist, Orthopedic	85	84	Physical Therapy	1
N	19	2251P0200X	Physical Therapist, Pediatrics	85	84	Physical Therapy	1
N	19	2251S0007X	Physical Therapist, Sports	85	84	Physical Therapy	1
N	19	261QP2000X	Physical Therapy	85	84	Physical Therapy	1
K	19	363A00000X	Physician Assistant	PA	86	Physician Assistant	2
K	19	363AM0700X	Physician Assistant	PA	86	Physician Assistant	2
K	19	363AS0400X	Physician Assistants & Advanced Practice Nursing Providers/Physician Assistant, Surgical	PA	86	Physician Assistant	2
K	19	364SA2200X	Physician Assistants & Advanced Practice Nursing Providers/ Nurse Practitioner, Adult Health	PA	86	Physician Assistant	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
K	19	364SP0808X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health	PA, 86	86	Physician Assistant	2
K	19	364S00000X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist	PA, 86	86	Physician Assistant	2
K	19	364SE0003X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Emergency	PA, 86	86	Physician Assistant	2
K	19	364SC0200X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Critical Care Medicine	PA, 86	86	Physician Assistant	2
K	19	364SM0705X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Medical-Surgical	PA, 86	86	Physician Assistant	2
K	19	364SP0810X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health, Child & Family	PA, 86	86	Physician Assistant	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
K	19	363LG0600X	Physician Assistants & Advanced Practice Nursing Providers/Nurse Practitioner, Gerontology	PA, 86	86	Physician Assistant	2
K	19	364SA2100X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Acute Care	PA, 86	86	Physician Assistant	2
K	19	364SC1501X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Community Health/Public Health	PA, 86	86	Physician Assistant	2
K	19	364SF0001X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Family Health	PA, 86	86	Physician Assistant	2
K	19	364SP0200X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Pediatrics	PA, 86	86	Physician Assistant	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
K	19	364SP0809X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Psychiatric/Mental Health, Adult	PA, 86	86	Physician Assistant	2
K	19	364SX0200X	Physician Assistants & Advanced Practice Nursing Providers/Clinical Nurse Specialist, Oncology	PA, 86	86	Physician Assistant	2
P	20	2086S0122X	Surgeon, Plastic and Reconstructive	69	54	Plastic Surgery	3
P	20	208200000X	Surgeon, Plastic Surgery	69	54	Plastic Surgery	3
P	20	2081P0004X	Allopathic & Osteopathic Physicians/Obstetrics & Gynecology, Female Pelvic Medicine and Reconstructive Surgery	63	54	Plastic Surgery	3
P	20	261QU0200X	Female Pelvic Medicine & Reconstructive Surgery	63	54	Plastic Surgery	3
P	20	2082S0099X	Surgeon, Plastic Surgery Head & Neck	69	54	Plastic Surgery	3
P	20	2082S0105X	Surgeon, Plastic Surgery of Hand	69	54	Plastic Surgery	3

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
Y	35	213E00000X	Podiatrist	47	54	Podiatry	3
Y	35	213ES0103X	Podiatrist, Foot and Ankle Surgery	47	54	Podiatry	3
Y	35	213ES0131X	Podiatrist, Foot Surgery	47	54	Podiatry	3
Y	35	213EG0000X	Podiatrist, General Practice	47	54	Podiatry	3
Y	35	213EP1101X	Podiatrist, Primary Podiatric Medicine	47	54	Podiatry	3
Y	35	213EP0504X	Podiatrist, Public Medicine	47	54	Podiatry	3
Y	35	213ER0200X	Podiatrist, Radiology	47	54	Podiatry	3
Y	35	213ES0000X	Podiatrist, Sports Medicine	47	54	Podiatry	3
P	20	207Q00000X	Family Medicine	12	14, AC	Primary Care	1
P	20	207QA0000X	Family Medicine, Adolescent	12	14, AC	Primary Care	1
P	20	207QA0505X	Family Medicine, Adult	12	14, AC	Primary Care	1
P	20	207QB0002X	Family Medicine, Bariatric	12	14, AC	Primary Care	1
P	20	207QG0300X	Family Medicine, Geriatric	12	14, AC	Primary Care	1
P	20	207QH0002X	Family Medicine, Hospice and Palliative Medicine	12	14, AC	Primary Care	1
P	20	207QS0010X	Family Medicine, Sports Medicine	12	14, AC	Primary Care	1
P	20	207QS1201X	Family Medicine, Sleep Medicine	12	14, AC	Primary Care	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	2084P0005X	Allopathic & Osteopathic Physicians/Preventive Medicine, Public Health & General Preventive Medicine	14	14, AC	Primary Care	1
P	20	208D00000X	General Practice	14	14, AC	Primary Care	1
P	20	207RG0300X	Internal Medicine, Geriatric Medicine	19	14, AC	Primary Care	1
P	20	207R00000X	Internal Medicine	19	14, AC	Primary Care	1
P	20	207RS0012X	Internal Medicine, Sleep Medicine	19	14, AC	Primary Care	1
P	20	207RS0010X	Internal Medicine, Sports Medicine	19	14, AC	Primary Care	1
P	20	207RC0200X	Internal Medicine, Critical Care	19	14, AC	Primary Care	1
Q	22	261QF0400X	Ambulatory Health Care Facilities/Clinic/Center FQHC	50	0	Primary Care	1
Q	22	261QR1300X	Ambulatory Health Care Facilities/Clinic/Center RHC	97	0	Primary Care	1
P	20	2084H0002X	Neuropsychiatry	48	54	Psychiatry	1
P	20	2084S0010X	Psychiatry & Neurology, Sports Medicine	48	54	Psychiatry	1
P	20	2084P0800X	Psychiatry	48	54	Psychiatry	1
P	20	2084B0002X	Psychiatry & Neurology, Bariatric Medicine	48	54	Psychiatry	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	2084P0804X	Psychiatry & Neurology, Child & Adolescent	49, AA	54, AA	Psychiatry	1
P	20	2084F0202X	Psychiatry & Neurology, Forensic Psychiatry	48	54	Psychiatry	1
P	20	2084P0805X	Psychiatry & Neurology, Geriatric Psychiatry	48	54	Psychiatry	1
P	20	2084P0015X	Psychiatry & Neurology, Psychosomatic Medicine	48	54	Psychiatry	1
P	20	2084S0012X	Psychiatry & Neurology, Sleep Medicine	48	54	Psychiatry	1
P	20	2085U0001X	Psychiatry & Neurology, Psychiatry	48	54	Psychiatry	1
P	20	2084N0400X	Psychiatry and Neurology, Neurology	22	54	Psychiatry	1
P	20	2084N0402X	Psychiatry and Neurology, Child Neurology	54, AA	54, AA	Psychiatry	1
M	19	103G00000X	Clinical Neuropsychologist	82	82	Psychologist	1
M	19	103GC0700X	Clinical Neuropsychologist	82	82	Psychologist	1
M	19	103TC0700X	Behavioral Health & Social Service Providers/Psychologist, Clinical	82	82	Psychologist	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
M	19	103T00000X	Behavioral Health & Social Service Providers/Psychologist	82	82	Psychologist	1
M	19	103TA0700X	Behavioral Health & Social Service Providers/Psychologist, Adult Development & Aging	82	82	Psychologist	1
M	19	103TC2200X	Behavioral Health & Social Service Providers/Psychologist, Clinical Child Adolescent	82	82	Psychologist	1
M	19	103TB0200X	Behavioral Health & Social Service Providers/Psychologist, Cognitive & Behavioral	82	82	Psychologist	1
M	19	103TC1900X	Behavioral Health & Social Service Providers/Psychologist, Counseling	82	82	Psychologist	1
M	19	103TE1000X	Behavioral Health & Social Service Providers/Psychologist, Educational	82	82	Psychologist	1
M	19	103TE1100X	Behavioral Health & Social Service Providers/Psychologist, Exercise and Sport	82	82	Psychologist	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
M	19	103TF0000X	Behavioral Health & Social Service Providers/Psychologist, Family	82	82	Psychologist	1
M	19	103TF0200X	Behavioral Health & Social Service Providers/Psychologist, Forensic	82	82	Psychologist	1
M	19	103TP2701X	Behavioral Health & Social Service Providers/Psychologist, Group Psychotherapy	82	82	Psychologist	1
M	19	103TH0004X	Behavioral Health & Social Service Providers/Psychologist, Health	82	82	Psychologist	1
M	19	103TH0100X	Behavioral Health & Social Service Providers/Psychologist, Health Service	82	82	Psychologist	1
M	19	103TM1700X	Behavioral Health & Social Service Providers/Psychologist, Men & Masculinity	82	82	Psychologist	1
M	19	103TM1800X	Behavioral Health & Social Service Providers/Psychologist, Mental Retardation	82	82	Psychologist	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
M	19	103TP0016X	Behavioral Health & Social Service Providers/Psychologist, Prescribing	82	82	Psychologist	1
M	19	103TP0814X	Behavioral Health & Social Service Providers/Psychologist, Psychoanalysis	82	82	Psychologist	1
M	19	103TP2700X	Behavioral Health & Social Service Providers/Psychologist, Psychotherapy	82	82	Psychologist	1
M	19	103TR0400X	Behavioral Health & Social Service Providers/Psychologist, Rehabilitation	82	82	Psychologist	1
M	19	103TS0200X	Behavioral Health & Social Service Providers/Psychologist, School	82	82	Psychologist	1
M	19	103TW0100X	Behavioral Health & Social Service Providers/Psychologist, Women	82	82	Psychologist	1
P	20	207RP1001X	Internal Medicine, Pulmonary Disease	19	14, AC	Pulmonary Medicine	1
P	20	2085R0202X	Radiology, Diagnostic	55	54	Radiology, Diagnostic	3
P	20	2085N0700X	Neuroradiology	55	54	Radiology, Diagnostic	3

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	2085D0003X	Allopathic & Osteopathic Physicians/Diagnostic Neuroimaging	55	54	Radiology, Diagnostic	3
P	20	2085N0904X	Allopathic & Osteopathic Physicians/Nuclear Radiology	55	54	Radiology, Diagnostic	3
P	20	2085R0203X	Allopathic & Osteopathic Physicians/ Therapeutic Radiology	55	54	Radiology, Diagnostic	3
P	20	207U00000X	Nuclear Medicine	24	54	Radiology, Diagnostic	3
P	20	207UN0903X	Nuclear Medicine, In vivo, In vitro	24	54	Radiology, Diagnostic	3
P	20	207UN0901X	Nuclear Medicine, Nuclear Cardiology	24	54	Radiology, Diagnostic	3
P	20	207UN0902X	Nuclear Medicine, Imaging and Therapy	24	54	Radiology, Diagnostic	3
P	20	207RM1200X	Internal Medicine, Magnetic Resonance Imaging	19	14, AC	Radiology, Diagnostic	3
P	20	2085P0229X	Diagnostic Ultrasound Radiology	55	54	Radiology, Diagnostic	3
P	20	2085B100X	Body Imaging	55	54	Radiology, Diagnostic	3
E	10	251S00000X	Community Behavioral Health	20	20	Rehabilitative Behavioral Health	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
V	22	251300000X	Local Education Agency	95	95	Rehabilitative Behavioral Health	1
P	20	207NI0002X	Allopathic & Osteopathic Physicians/Physical Medicine & Rehabilitation, Spinal Cord Injury Medicine	29, 19	14, 54	Rehabilitation/ Physical Medicine	2
P	20	208100000X	Physician, Physical Medicine & Rehabilitation	19, 29	14, 54, AC	Rehabilitation/ Physical Medicine	2
P	20	204C00000X	Physician, Neuromusculoskeletal Medicine, Sports Medicine	19, 29	14, 54, AC	Rehabilitation/ Physical Medicine	2
P	20	2081S0010X	Physician, Physical Medicine & Rehab, Sports Medicine	19, 29	14, 54, AC	Rehabilitation/ Physical Medicine	2
P	20	204D00000X	Physician, Neuromusculoskeletal Medicine & OMM	19, 29	14, 54, AC	Rehabilitation/ Physical Medicine	2
P	20	2083X0100X	Physician, Occupational Medicine	29	54	Rehabilitation/ Physical Medicine	2
P	20	207RR0500X	Internal Medicine, Rheumatology	19	14, AC	Rheumatology	2
J	19	231H00000X	Speech, Language and Hearing/Audiologist	4	4	Speech and Audiology Therapy	1
J	19	237600000X	Audiologist- Hearing Aid Fitter	4	4	Speech and Audiology Therapy	1

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
J	19	231HA2400X	Speech, Language and Hearing/Audiologist, assistive Tech	4	4	Speech and Audiology Therapy	1
N	19	235Z00000X	Speech, Language and Hearing Service Providers	04, 84, 85,87	04, 84, 85,87	Speech and Audiology Therapy	1
G	10	276400000X	Rehabilitation Substance Use Disorder	90	90	Substance Abuse Treatment	2
G	10	324500000X	Substance Abuse Disorder	90	90	Substance Abuse Treatment	2
G	10	261QR0405X	Clinic/Center-Rehab Substance Abuse	90	90	Substance Abuse Treatment	2
M	19	101YA0400X	Behavioral Health & Social Service Providers/Addiction	LT, PC, SW, PE, LW	LT, PC, SW, PE, LW	Substance Abuse Treatment	2
M	19	103TA0400X	Behavioral Health & Social Service Providers/Psychologist, Addiction	82	82	Substance Abuse Treatment	2
L	20	207LA0401X	Anesthesiology, Addiction Medicine	3	3	Substance Abuse Treatment	2
P	20	207QA0401X	Family Medicine, Addiction Medicine	12	14, AC	Substance Abuse Treatment	2
P	20	2084P0802X	Addiction Psychiatry	48	54	Substance Abuse Treatment	2
P	20	207RA0401X	Internal Medicine, Addiction Medicine	19	14, AC	Substance Abuse Treatment	2
P	20	207T00000X	Surgeon, Neurological	65	54	Surgery Neurological	2

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
P	20	2086X0206X	Surgeon, Oncology	63	54	Surgery Oncology	2
P	20	204F00000X	Surgeon, Transplant	63	54	Surgery	2
P	20	2085B0100X	Radiology, Vascular and Interventional	56	54	Therapeutic Radiology	3
P	20	2085R0001X	Radiation Oncology	56	54	Therapeutic Radiology	3
P	20	208G00000X	Surgeon, Thoracic	61, 63	54	Thoracic Surgery	2
P	20	207VF0040X	Urologist	N/A	N/A	Urology	1
P	20	208800000X	Urology	N/A	N/A	Urology	1
P	20	2086S0129X	Surgeon, Vascular	61, 63	54	Vascular Surgery	2
	19	367H00000X	Anesthesiology Assistant	not currently enrolled by Medicaid	not currently enrolled by Medicaid	Not Categorized due to service category not specific enough to categorize or outside of managed care service array	N/A
	20	174400000X	Other Service Providers	N/A	N/A	Not Categorized due to service category not specific enough to categorize or outside of managed care service array	N/A
	22	251V00000X	Voluntary or Charitable Organization	N/A	N/A	Not Categorized due to service category not specific enough to categorize or outside of managed care service array	N/A

Subfile	Medicaid Provider Type	Taxonomy Code	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
	22	171W00000X	Contractor Other Service Provider	N/A	N/A	Not Categorized due to service category not specific enough to categorize or outside of managed care service array	N/A
	20	207RT0003X	Internal Medicine, Transplant Hepatology	19	14, AC	Not Categorized due to service category not specific enough to categorize or outside of managed care service array	N/A
	20	207RI0008X	Internal Medicine, Hepatology	19	14, AC	Not Categorized due to service category not specific enough to categorize or outside of managed care service array	N/A

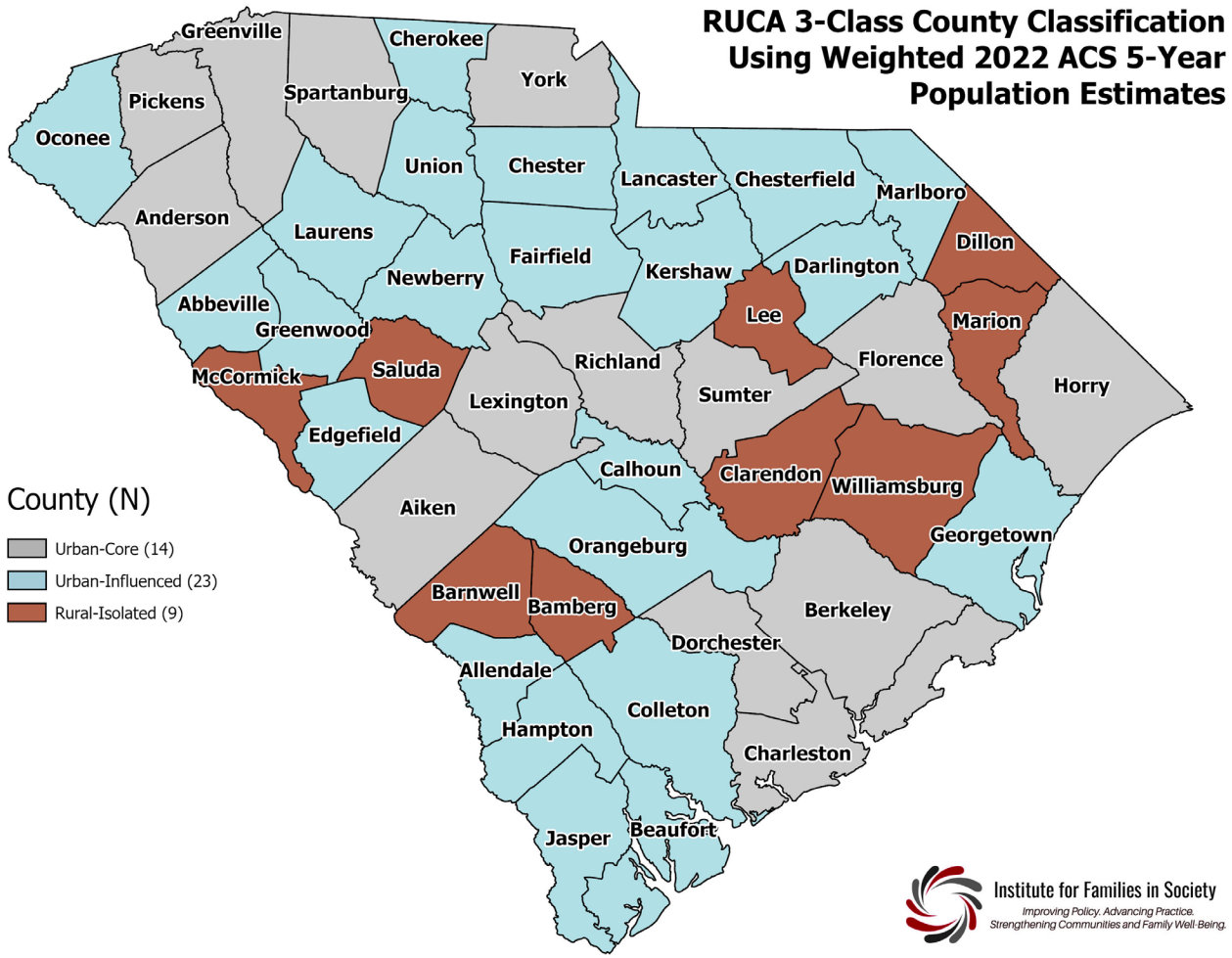
Service Groups Ancillary & Professional Providers

Network Adequacy Chart Service Groups Ancillary and Professional- Group Specialty							
Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
	21	261QP2300X	Primary Care				
	21	261QM1300X	MultiSpecialty Group Practice				
	21	193200000X	Group/Multi-Specialty				
	21	193400000X	Group/Single-Specialty				
	22	261QM1300X	MultiSpecialty Group Practice				
	22	193200000X	Group/Multi-Specialty				
	22	193400000X	Group/Single-Specialty				
	34	261QM1300X	MultiSpecialty Group Practice				
	34	193200000X	Group/Multi-Specialty				
	34	193400000X	Group/Single-Specialty				
	36	261QM1300X	MultiSpecialty Group Practice				
	36	193200000X	Group/Multi-Specialty				

Subfile	Medicaid Provider Type	Bill Type (Institutional Claim Types Only)	Taxonomy Description	Practice Specialty	Pricing Specialty	Medicaid Service Grouping	Contract Status
	36	193400000X	Group/Single-Specialty				
	38	261QM1300X	MultiSpecialty Group Practice				
	38	193200000X	Group/Multi-Specialty				
	38	193400000X	Group/Single-Specialty				
	41	193200000X	Group/Multi-Specialty				
	41	193400000X	Group/Single Specialty				
	41	332H00000X	Group Eyewear Supplier				

APPENDIX E

County Rurality Classifications



The following chart is a list of Rural-Urban Commuting Area Codes (RUCA) classifications for all South Carolina counties, organized by three county classifications.

Urban Core	**Urban Influenced**	**Rural Isolated**
Anderson	Oconee	McCormick
Pickens	Cherokee	Saluda
Greenville	Union	Barnwell
Spartanburg	Laurens	Bamberg
York	Abbeville	Clarendon
Aiken	Greenwood	Williamsburg
Lexington	Newberry	Lee
Richland	Chester	Dillon
Sumter	Fairfield	Marion
Florence	Lancaster	
Horry	Kershaw	
Dorchester	Chesterfield	
Berkeley	Darlington	
Charleston	Marlboro	
	Calhoun	
	Orangeburg	
	Georgetown	
	Allendale	
	Hampton	
	Jasper	
	Beaufort	
	Colleton	
	Edgefield	

APPENDIX F

Exhibits List

APPENDIX F- Exhibits List

Exhibit 1	SCDHHS High Cost No Experience Drug List
Exhibit 2	Managed Care Organization Comprehensive Drug List Requirements Matrix
Exhibit 3	Healthy Connections Choices, Expanded Benefits Chart Webpage
Exhibit 4	Institution for Mental Disease Report
Exhibit 5	Provider Network Submission Template
Exhibit 6	Standardized List of Hospitals in South Carolina
Exhibit 7	New Patient Values
Exhibit 8	Language Codes List
Exhibit 9	Manual Maternity Kicker Request Schedule
Exhibit 10	Premium Payment Adjustments Report
Exhibit 11	Monthly Premium Recoupment Reports
Exhibit 12	Dual Medicare/Medicaid Report
Exhibit 13	FY 2024 Quarterly Hospital and Teaching Physician Directed Payment Schedule
Exhibit 14	FY 2025 Quarterly Teaching Physician Directed Payments Schedule
Exhibit 15	FY 2025 HAWQ Hospital Directed Payment Schedule
Exhibit 16	FY 2025 Independent Community Pharmacy Directed Payment Schedule
Exhibit 17	FQHC/RHC Report Schedule
Exhibit 18	RHC Wrap Payment Methodology Effective October 1, 2023
Exhibit 19	FQHC Wrap Payment Methodology Effective October 1, 2023
Exhibit 20	Composite Score Measures for Members in SPLIP
Exhibit 21	Statewide Pharmacy Lock-In Program Schedule
Exhibit 22	Minimal Change Attestation Form
Exhibit 23	Marketing Activities Submission Log
Exhibit 24	Quarterly & Annual EQI Reporting Schedules
Exhibit 25	Annual CAHPS and NCQA Member Level Data Files