CONTRACT BETWEEN

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND

<< CONTRACTOR >>

FOR THE PURCHASE AND PROVISION OF MEDICAL SERVICES UNDER THE SOUTH CAROLINA MEDICAID MANAGED CARE PROGRAM

DATED AS OF

JULY 1, 2024

VERSION:

INCLUSIVE OF AMENDMENT II

DATED AS OF

JULY 1, 2025

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CONTRACT BETWEEN SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES AND STANDARD MCO CONTRACTOR FOR THE PURCHASE AND PROVISION OF MEDICAL SERVICES UNDER THE SOUTH CAROLINA MEDICAID MCO PROGRAM DATED AS OF July 1, 2024.

This Contract is entered into as of the first day of July 2024 by and between the South Carolina Department of Health and Human Services, Post Office Box 8206, 1801 Main Street, Columbia, South Carolina, 29202-8206, hereinafter referred to as "Department" and <<MCO LEGAL ENTITY NAME>>, <<Provider Address>>, hereinafter referred to as “CONTRACTOR”.

WHEREAS, the Department is the single state agency responsible for the administration of the South Carolina State Plan for Medical Assistance under Title XIX of the Social Security Act (State Plan) and makes all final decisions and determinations regarding the administration of the Medicaid Program; and

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

WHEREAS, the CONTRACTOR is an entity qualified to enter into a risk based contract in accordance with § 1903(m) of the Social Security Act and 42 CFR § 438 (2008, as amended), including any amendments hereto, and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 CFR § 438.2; and

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

WHEREAS the CONTRACTOR warrants that it is capable of providing or arranging for health care services provided to covered persons for which it has received a Capitation Payment; and

WHEREAS, the CONTRACTOR is engaged in said business and is willing to provide such health care services to Medicaid Managed Care Members upon and subject to the terms and conditions stated herein;

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

Section 1. GENERAL PROVISIONS

1.1 Effective Date and Term

This Contract shall be effective no earlier than the date it has been approved by CMS and shall continue in full force and effect from July 1, 2024 until June 30, 2027, unless terminated prior to that date in accordance with the provisions of this Contract. The parties agree that certain deliverables required under this Contract, including but not necessarily limited to reports may be due on dates that may occur outside of the term of this Contract. In the event that deliverables are due after the termination of this Contract, Contractor agrees to provide those deliverables by the due date.

1.2 Notices

Whenever notice is required to the other party, pursuant to this Contract, it shall be made in writing and delivered to that party. Delivery shall be deemed to have occurred (1) on the date of delivery, if made in person and a signed receipt is obtained; (2) on the date of delivery, if delivered by nationally recognized overnight carrier and a receipt is obtained; or if three (3) Calendar Days have elapsed after posting when sent by registered or certified mail, return receipt requested, whichever occurs first. Notices shall be addressed as follows:

In case of notice to CONTRACTOR:

«provider»
«Address1»
«citystatezip»

In case of notice to the Department:
South Carolina Department of Health and Human Services
Deputy Director, Health Programs
1801 Main Street Post Office Box 8206
Columbia, South Carolina 29202-8206

cc: Program Director Health Policy
Program Director Managed Care
Contracts

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

1.3 Definitions

As used in this Contract, capitalized terms shall have the defined meanings set forth in *Appendix A*.

1.4 Entire Agreement

The Contractor shall comply with all the provisions of the Contract, including amendments and appendices, and shall act in good faith in the performance of the provisions of said Contract. The Contractor shall be bound by the contractual requirements stated herein. Further operational guidance regarding approved procedures will be detailed in applicable Provider manuals and the Managed Care Report Companion, and Managed Care Process & Procedure Manual In the event of a dispute between the Contractor and the Department's interpretation of this Contract, the Contractor acknowledges and agrees that the Department's interpretation shall control. The Contractor shall comply with all applicable Department Policies and Procedures in effect throughout the Contract period. The Contractor shall comply with all Department bulletins and manuals relating to the provision of services under this Contract. The Contractor agrees that it is responsible for being familiar with all relevant Department bulletins, Policies, Procedures, and manuals that relate in any way to the provisions of this Contract. Where the provisions of the Contract differ from the requirements set forth elsewhere, then the Contract provisions shall control. The Department, at its discretion, will issue Medicaid bulletins to inform the Contractor of changes in Policies and Procedures that may affect this Contract. The Department is the only party to this Contract that may issue Medicaid bulletins.

1.5 Federal Approval of Contract

Pursuant to 42 CFR 438.806 (2024, as amended), this Contract and all terms and conditions stated herein are subject to prior approval by the CMS Regional Office. If CMS does not approve this Contract, then this Contract will be considered null and void.

1.6 Medicaid Managed Care Organization Requirements

1.6.1 New Applicants

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

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

1.6.2 Existing Contractor – MCO Certification Process

1.6.2.1 The Contractor must at all times comply with all applicable South Carolina Department of Insurance (SCDOI) requirements.

1.6.2.2 As a condition of continued participation in the Medicaid managed care program during the term of this agreement, the Contractor must meet the certification requirements contained within the Department's MCO Certification process. The certification process assesses performance across a range of operational, financial, and quality-based criteria.

1.6.2.4 No less than once, During the term of this contract, the Department will officially communicate its intent to initiate the certification process with Contractor. Official notice of the certification will include formal timelines and instructions for submission of required standards and elements and the evaluation criteria used to review performance of the Contractor by the Department.

1.6.2.5 The Department may refine certification-related review processes or materials over the contract term, while ensuring that certification continues to be based on defined standards, elements and evaluation criteria that are made accessible to the Contractor.

1.6.2.4 Failure to meet certification requirements may result in compliance actions in accordance with the terms of this Contract, up to and including contract termination. In such cases, the Contractor remains subject to all applicable member transition requirements and the termination provisions outlined in Section 17 and agrees to cooperate with all requirements for appropriate transition and continuity of care for impacted members.

Section 2. CONTRACTOR ADMINISTRATIVE REQUIREMENTS

The Contractor shall oversee and remain accountable for all functions and responsibilities of the Contractor arising pursuant to this Contract, including any functions and/or responsibilities the Contractor delegates to a Subcontractor, partner, affiliate, or other party.

2.1 General Administrative Requirements

The Contractor shall:

2.1.1 Have in place the organizational, operational, managerial, and administrative systems capable of fulfilling all Contract requirements.

2.1.2 At a minimum, operate Monday through Friday, 8am to 6pm ET excluding state holidays.

2.1.3 Not employ or contract with any individual who has been debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order 12549 (42 CFR 438.610 (a) & (b); 42 CFR 1001.1901(b); 42 CFR 1003.102(a)(2)).

2.1.4 Be obligated to screen all employees and Subcontractors to determine whether any of them have been excluded from participation in any state or federal health care programs, using the same process as for Providers as outlined in Section 11 of this Contract.

2.1.5 Ensure all staff, Providers and Subcontractors have appropriate training, education, experience, liability coverage, and orientation to fulfill the requirements of their positions.

2.1.6 Employ sufficient personnel, of appropriate education, training, experience, and/or licensure to ensure that the requirements set forth in this Contract are met in an accurate and timely fashion.

2.1.7 Maintain compliance with contractual obligations. If noncompliance exists, the Department may employ additional monitoring and regulatory action including, but not limited to, requiring the Contractor to hire additional staff. Nothing in this section should be construed to prevent the Department from availing itself of any other remedies specified in this Contract, including liquidated damages, sanctions, and/or termination. If, at any point, the Contractor fails to maintain compliance with its contractual obligations, the Department reserves the right to enact any or all corrective measures defined in this Contract. (See 42 CFR 438.702(b) (2024, as amended)

2.1.8 Be responsible for costs associated with on-site audits or other oversight activities that result when functions are located outside of the State of South Carolina.

2.1.9 Limit an individual staff member that is not identified as Full-Time Equivalent (FTE) employee to occupying a maximum of two (2) Key Personnel or Additional Staffing positions. Changes to this provision require prior approval from the Department.

2.1.9.1 The Contractor shall submit to the Department on an annual basis and upon request by the Department, a current organizational chart depicting all functions including mandatory functions, number of employees in each functional department, and key managers responsible for the functions.

2.1.9.2 The Contractor shall document, for each Key Personnel position, the portion of time allocated to each Medicaid contract as well as all other lines of business.

2.2 Staffing Requirements

The Contractor's staff shall include, at a minimum, the positions identified in this Section.

2.2.1 Key Personnel

The Contractor shall:

2.2.1.1 Notify the Department in writing of any change to an individual identified as Key Personnel in *Exhibit 1* within ten (10) Business Days of the change. Notification shall include a curriculum vitae for all Key Personnel, defined in this Contract as management and having a designation as 1.0 FTE.

2.2.1.2 Receive prior approval for any changes to the Contractor's Key Personnel. If the Contractor submits for approval from the Department changes to Key Personnel, the Department shall respond to the request within ten (10) Business days. No response from the Department within ten (10) Business Days of notification of change shall be considered approval of the Key Personnel assignment.

2.2.1.3 In the event that an employee in a Key Personnel position leaves the Contractor's employment or a Key Personnel position is vacated, the Contractor must begin the process of rehiring for the Key Personnel position within ten (10) Business Days of the position being vacated.

2.2.1.4 In the event that any Key Personnel position remains vacated for more than six (6) months, the Contractor must submit a plan of action to the Department that identifies the hiring strategy within thirty (30) days after the sixth month period has ended.

2.2.2 Additional Required Staff

In addition to the Key Personnel identified in Exhibit 1, Contractor shall employ sufficient staff to effectively manage operations required under this Contract. Such staff shall include, at a minimum, the staff identified in *Exhibit 2*.

Exhibit 1- Key Personnel, by Position, by In- and Out-of-State, July 1, 2024

POSITIONS[1]	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE[2] Number	IN-STATE[3] South Carolina	Specific to Profession	IN-STATE[3] South Carolina	
Administrator (CEO, COO, Executive Director, etc.)	A full-time administrator shall have clear authority over general administration and implementation of requirements set forth in the Contract, including responsibility to oversee the budget and accounting systems implemented by the Contractor and authority to direct and prioritize work, regardless of where performed.	1.0	Required			07/01/2024
Chief Financial Officer (CFO)	The Chief Financial Officer (CFO) oversees the budget and accounting systems implemented by the Contractor.					07/01/2024
Contract Manager	The Contract Manager will serve as the primary point-of-contact between Contractor and the Department and has decision making authority for the Health Plan. The primary functions of the Contract Manager may include but are not limited to coordinate the tracking and submission of all Contract deliverables; field and coordinate responses to Department inquiries, and coordinate the preparation and execution of Contract requirements, such as random and periodic audits and ad hoc visits.	1.0	Required			07/01/2024

POSITIONS[1]	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE[2] Number	IN-STATE[3] South Carolina	Specific to Profession	IN-STATE[3] South Carolina	
Medical Director	A Physician licensed in the State of South Carolina to oversee and be responsible for the proper provision of Benefits to Members under this Contract. The Medical Director must have substantial involvement in the Quality Assurance activities	1.0	Required	Required	Required	07/01/2024
Pharmacy Director	The Pharmacy Director must be appropriately licensed as a Pharmacist in the state in which they operate and oversees and is responsible for the proper provision of covered pharmaceuticals to the Members under this Contract.			Required		07/01/2024
Quality Improvement (QI) and/or Quality Management (QM) Coordinator, Manager, Director	The Quality Improvement Director may have a certification as a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers. This position is responsible for the administration and oversight of the Quality Improvement Program required by this Contract.	1.0	Required			07/01/2024

POSITIONS[1]	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE[2] Number	IN-STATE[3] South Carolina	Specific to Profession	IN-STATE[3] South Carolina	
Utilization Management (UM) Coordinator, Manager, Director	The Utilization Management Coordinator is responsible for all UM activities, including but not limited to overseeing Prior Authorizations, referral functions and inpatient certification, including concurrent and retrospective reviews. The UM Director must have experience in utilization management as specified in this Contract and 42 CFR 438.210 (2024, as amended). This person shall be a registered nurse (RN) licensed in the State of South Carolina and shall ensure that UM staff have appropriate clinical backgrounds to make utilization management decisions. Apart from the RN license, this person may have a certification as a Certified Professional in Health Care Quality (CPHQ) by the National Association for Health Care Quality (NAHQ) and/or Certified in Health Care Quality and Management (CHCQM) by the American Board of Quality Assurance and Utilization Review Providers; however, the RN license is the only professional credential requirement for this position.			Required	Required	07/01/2024
Claims and Encounter Manager/Administrator	The Claims and Encounter Manager/Administrator shall ensure prompt and accurate Provider Claims processing. The functions of the Claims Administrator are: develop and implement Claims processing systems capable of paying Claims in accordance with state and federal requirements; develop processes for cost avoidance; ensure minimization of Claims Recoupments; meet Claims processing timelines; and meet Department Encounter reporting requirements.					07/01/2024

POSITIONS[1]	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE[2] Number	IN-STATE[3] South Carolina	Specific to Profession	IN-STATE[3] South Carolina	
Compliance Officer	The Compliance Officer is accountable to senior management and will be responsible for Program integrity (PI) activities required under 42 CFR 438.608 (2024, as amended), including but not limited to overseeing and validating PI-related reporting,, validating sanctions and Prepayment lists, responding to PI/MFCU request, ensuring dated PI request are delivered timely and accurately, attending all PI scheduled meetings, coordinating PI/MCO activities, and ensuring Contract requirements are met.	1.0	Required			07/01/2024
Provider Service Manager	The Provider Service Manager coordinates communications between the Contractor and its In Network Providers and ensures sufficient Provider services staff to enable Providers to receive prompt resolution to their problems or inquiries and appropriate education about participation in the Managed Care Program and maintaining a sufficient Provider Network.	1.0	Required			07/01/2024
Member Service Manager	The Member Services Manager shall coordinate communications with Members; serve in the role of Member advocate; coordinate issues with appropriate areas within the organization; resolve Member inquiries/problems and meet standards for resolution, telephone abandonment rates and telephone hold times; and assist Members when necessary to access high quality integrated medical and Behavioral Health care with Cultural Competency.	1.0	Required			07/01/2024
Legal	Staff assigned to provide legal advice and assistance for the Contractor.					07/01/2024

POSITIONS[1]	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE[2] Number	IN-STATE[3] South Carolina	Specific to Profession	IN-STATE[3] South Carolina	
Interagency Liaison	Interagency Liaison shall be responsible for coordinating the provision of services with HCBS waivers, community resources, the Department and other state agencies, and any other community entity that traditionally provides services for Members.		Required			07/01/2024
Other Medical Personnel	Clinical personnel must be appropriately licensed and/or certified within their profession and within the state(s) in which they operate.				Required	07/01/2024
Behavioral Health Director	The Behavioral Health professional shall be appropriately licensed within their profession and the state(s) they operate, and shall have at least three (3) years of experience in mental health and/ or substance abuse.	1.0	Required		Required	07/01/2024

Notes:
[1]Key position identified in this contract
[2]FTE# = Full-Time Equivalent (*aka* FTE) and is defined as an employee that is dedicated to the indicated role and works a minimum of thirty-two (32) hours per week.
[3]In the Column titled "Located In-State" a designation of "Required" means that the position must be located within the State of South Carolina.

Exhibit 2- Additional Required Staff, July 1, 2024

POSITIONS[1]	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE[2] Number	IN-STATE[3] South Carolina	Specific to Profession	IN-STATE[3] South Carolina	
Utilization Review Staff	Responsible for Prior Authorizations and current reviews. This staff shall be appropriately licensed for their profession in the state in which they are located..			Required		07/01/2024
Quality Assessment and Performance Improvement Staff	Sufficient staff qualified by training and experience to be responsible for the operation and success of the Quality Assessment and Performance Improvement Program (QAPI). The QAPI staff shall be accountable for Quality outcomes in all of the Contractor's own in network Providers, as well as out of network Providers.					07/01/2021
Case Management Staff	The Contractor shall have staff located in South Carolina and provide Care Coordination and Case Management for Members with special health care needs.					07/01/2024

POSITIONS[1]	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE[2] Number	IN-STATE[3] South Carolina	Specific to Profession	IN-STATE[3] South Carolina	
Intensive Case Management Staff	Those staff identified as providing Intensive Case Management must retain a 1:60 caseload ratio.		Required			01/01/25
Compliance/Program Integrity Staff	The Contractor shall have adequate staffing and resources to fulfill the Program Integrity and Compliance requirements of this Contract, to investigate all reported incidents, and to develop and implement the necessary systems and Procedures for preventing and detecting potential Fraud and Abuse activities.					07/01/2024
Program Integrity Coordinator	The Contractor must provide a staff member, with hands on knowledge and decision-making capabilities regarding Program integrity, to coordinate Fraud, Waste & Abuse activities and efforts with the Department's Program Integrity/SUR Division. This position may count as one (1) of the two (2) Investigative/Review staff indicated below.	1	Required			07/01/2024

POSITIONS[1]	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE[2] Number	IN-STATE[3] South Carolina	Specific to Profession	IN-STATE[3] South Carolina	
Program Integrity FWA Investigative/Review Staff	The Contractor must furnish a minimum of two (2) FTE Program Integrity Fraud, Waste and Abuse Investigator(s) or Reviewer(s) dedicated solely to post-payment reviews of Claims for the initial 100,000 Members enrolled with the Contractor. The Contractor must furnish one (1) additional FTE for each additional 100,000 Members enrolled with the Contractor. Each Investigative/Reviewer staff must have at least one (1) of the following designations: • Registered Nurse (RN) • Actively certified by the American Academy of Professional Coders (AAPC) as a Certified Professional Coder (CPC) • Actively professionally certified by the American Health Information Management Association (AHIMA) as a Certified Coding Specialists-Physician-based (CCS- P®). • Actively credentialed as a Certified Fraud Examiner (CFE) awarded by the Association of Certified Fraud Examiners (ACFE) association. • Currently designated as an Accredited Health Care Fraud Investigator (AHFI) granted by the National Health Care Anti-Fraud Association (NHCAA). • Investigative/Law Enforcement background • Other medical credentials: such as Social Worker, Dental Hygienist, Pharmacist, etc.	2.0/ per initial 100,000 Members 1.0/ per each additional 100,000 Members	Required for 2 staff			07/01/2024

POSITIONS[1]	POSITION DESCRIPTION	REQUIREMENTS				EFFECTIVE DATE (MM/DD/YYYY)
		LOCATION		LICENSURE		
		FTE[2] Number	IN-STATE[3] South Carolina	Specific to Profession	IN-STATE[3] South Carolina	

Notes:
[1]Additional staff position identified within this contract
[2]FTE# = Full-Time Equivalent (*aka* FTE) and is defined as an employee that works a minimum of thirty-two (32) hours per week.
[3]In the Column titled "Located In-State" a designation of "Required" means that the position must be located within the State of South Carolina.

2.3 Training Requirements

2.3.1 Training Program Requirements

The Contractor shall:

2.3.1.1 Be responsible for training all of its employees, In Network Providers, and Subcontractors to ensure adherence to the Medicaid Managed Care Program Policies and Procedures and Medicaid laws and regulations.

2.3.1.2 Be responsible for conducting ongoing training on the Medicaid Managed Care Program Policies and distribution of updates for its employees, In Network Providers, and Subcontractors.

2.3.1.3 Hold Benefit/direct service Provider training sessions in at least four (4) regional locations throughout the State at least once a year.

2.3.1.4 Develop and maintain an annual Provider training plan and provide to the Department a copy of the Contractor's annual provider training plan.

2.4 Licensing Requirements

All of the Contractor's In Network Providers must be licensed and/or certified by the appropriate licensing body or standard-setting agency, as applicable.

The Contractor shall:

2.4.1 Ensure all of the Contractor's In Network Providers comply with all applicable statutory and regulatory requirements of the South Carolina Medicaid Program and be enrolled in the program.

2.4.2 Be responsible for assuring that all persons, whether employees, agents, Subcontractors, or anyone else acting for or on behalf of the Contractor, are properly licensed at all times under applicable state law and/or regulations and are not debarred, suspended or otherwise ineligible for participation in the South Carolina Medicaid Program and/or the Medicare Program.

2.4.3 Ensure all health professionals and health care facilities used in the delivery of services by or through the Contractor possess a current license to practice or operate in the State in which the service is delivered. The Department may withhold part or all of the Capitation Payment due the Contractor if the service is provided or authorized by unlicensed personnel. The Department may also refer the matter to the appropriate licensing authority for action.

2.4.3.1 In the event the Department discovers that any of the Contractor's In Network Providers are not appropriately licensed, the Department will notify the Contractor. The Contractor shall, upon notification, remove the In Network Provider from its Provider Network and the In Network Provider shall discontinue providing services to Members immediately.

2.4.3.2 Upon proper licensing by the appropriate authority and approval by the Department, the Contractor may reinstate the In Network Provider to provide services to Members.

2.5 Subcontracting and Delegation of Authority

Notwithstanding any relationship(s) that the Contractor may have with any Subcontractor, the Contractor maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract. (See 42 CFR 438.230(b)(1)(2024, as amended))

The Contractor shall:

2.5.1 Refer to all delegates as Subcontractors.

2.5.2 Refer to all written agreements for delegated activities as Subcontracts.

2.5.3 Utilize written agreements for all Subcontracting and delegation of activities. A Network Provider Agreement shall not be considered a delegated agreement/Subcontract.

2.5.4 Be responsible for ensuring that the Subcontractor adheres to all applicable requirements set forth in this Contract to the extent the Contractor has elected to utilize Subcontractors to carry out the terms of this Contract. (See 42 CFR 438.230(c)(1)(ii)(2024, as amended))

2.5.5 Specify the delegated activities and reporting responsibilities of the Subcontractor within the Subcontract. (See 42 CFR 438.230(c)(1)(i)(2024, as amended))

2.5.6 Include in the Subcontracts provisions for revoking the delegation or imposing other remedies if the Department or the Contractor determines Subcontractor's performance is unsatisfactory. (See 42 CFR 438.230(c)(1)(iii) (2024, as amended))

2.5.7 Ensure Subcontractors meet any specified accreditation standards, including but not limited to, active accreditation or actively pursuing accreditation by a nationally recognized accrediting body when the Contract or applicable provider manuals specify an accreditation requirement.

2.5.8 Monitor the Subcontractor's performance on an ongoing basis, to include an annual review. This includes conducting formal reviews according to a review schedule that is consistent with industry standards, state laws, and as set forth by the Department, as applicable.

2.5.9 Take corrective action if the Contractor and/or Subcontractor identify deficiencies or areas for improvement related to the Subcontractor's performance of the delegated activity.

2.5.10 Ensure the Contractor's rights and obligations set forth in this Section are not amended or altered if the Contractor's Subcontractor subcontracts any of the delegated activity to another, and all Subcontractors and sub-subcontractors remain subject to the requirements of this Section.

2.5.11 Submit prior notice of any further delegation by the Subcontractor to the Department.

2.5.12 Require the Subcontractor to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and provisions of this Contract. (See 42 CFR 438.230(c)(2) (2024, as amended)).

2.5.13 Access the Office of Inspector General electronic databases on a monthly basis to identify whether any individuals with whom the Contractor has a relationship are prohibited from receiving federal funds.

2.5.14 Require all Subcontractors to make available, for purposes of an audit, evaluation, or inspection, by the State, CMS, the HHS Inspector General, the Comptroller General or their designees, its premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems relating to its Members. (See 42 CFR 438.230(c)(3)(ii) (2024, as amended))

2.5.15 Ensure the Subcontractors agree the right to audit exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. (See 42 CFR 438.230(c)(3)(iii) (2024, as amended))

2.5.16 Ensure the Subcontractors agree that if the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of Fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Subcontractor at any time. (See 42 CFR 438.230(c)(3)(iv) (2024, as amended))

2.5.17 The State, CMS, the HHS Inspector General, the Comptroller General, and their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Subcontractor, or of the Subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Contract. (See 42 CFR 438.230(c)(3)(i) (2024, as amended))

2.6 Subcontract Boilerplate Requirements

The Contractor shall:

2.6.1 Ensure all Subcontracts entered into by the Contractor for the purposes of administrating delegated activities on behalf of the Contractor include, verbatim, the Minimum Subcontractor Provisions (MSPs) contained in Appendix D to this Contract.

2.6.2 Submit every Subcontract, and subsequent revision thereto, to the Department for review to ensure required elements are included. All Subcontract boilerplate and subsequent revisions must be prior approved by the Department. After review, the Department may approve, deny, or require revision of submitted materials.

2.6.2.1 In lieu of sending every Subcontract to the Department for review, the Contractor shall submit a boilerplate template(s) Subcontract to the Department for review and prior approval. The Contractor may then use these approved boilerplate template(s) without submitting each individual Subcontract to the Department for review and approval.

2.6.2.2 The Contractor shall include with the submission of each Subcontract or boilerplate template a detailed summary of any Contractor duties or responsibilities that have been delegated to the Subcontractor.

2.6.2.3 The Contractor shall submit to the Department, prior to the execution of any Subcontract, information pertaining to the Contractor's intended Subcontractor.

2.6.3 Agree to a thirty (30) day Department review period in response to the Contractor's request for approval of a Subcontract, boilerplate template, and/or subsequent revisions to an existing Department-approved Subcontract or boilerplate template. The Department may, at its

discretion, halt the deadline for a response if the Department requires more time to review the submitted materials and formulate a response thereto. If the Department does not respond or notify the Contractor within thirty (30) days that more time is necessary for review, then the submission is considered approved by the Department.

2.6.4 Accept the Department's decision to communicate directly with: (a) the Contractor, (b) the governing body or (c) the parent corporation of the Contractor regarding the performance of a Subcontractor or the Contractor itself.

2.7 Network Provider Agreement Boilerplate Requirements

The Contractor shall:

2.7.1 Ensure all In Network Provider agreements s entered into by the Contractor for the purposes of executing responsibilities enumerated in this Contract include, verbatim, the Minimum Provider Provisions (MPPs) contained in Appendix E to this Contract.

2.7.2 Submit every In Network Provider agreement, and subsequent revision thereto, to the Department for review to ensure required elements are included. All In Network Provider agreements and subsequent revisions must be prior approved by the Department. After review, the Department may approve, deny, or require revision of submitted materials.

2.7.2.1 In lieu of sending every In Network Provider agreement for review, the Contractor shall submit a boilerplate template(s) Network Provider Agreement for In Network Providers to the Department for review and prior approval. The Contractor may then use these approved boilerplate templates to contract without submitting each individual agreement to the Department for review and approval.

2.7.2.2 Include with the submission of each In Network Provider agreement or boilerplate template a detailed summary of the services to be performed by the Provider.

2.7.3 Agree to a thirty (30) day Department review period in response to a Contractor's request for approval of an In Network Provider agreement, boilerplate template, and/or subsequent revisions to an existing Department- approved agreement or boilerplate template. The Department may, at its discretion, halt the deadline for a response if the Department requires more time to review the submitted materials and formulate a response thereto. If the Department does not respond or notify the Contractor within thirty (30) days that more time is necessary for review, then the submission is considered approved by the Department.

2.7.4 Accept the Department's decision to communicate directly with: (a) the Contractor, (b) the governing body or (c) the parent corporation of the Contractor regarding the performance of a In-Network Provider or the Contractor itself.

2.8 Provider Enrollment and Credentialing

2.8.1 Provider Enrollment

The Contractor shall:

2.8.1.1 Ensure that all individuals and entities within its Provider Network that provide services to Members are enrolled with the Department as South Carolina Medicaid Network Providers. For specific requirements on Provider enrollment, refer to the Department's website.

2.8.1.1.1 Upon request, the Contractor agrees to assist the Department with the revalidation of South Carolina Medicaid Network Providers in accordance with 42 CFR 455 Subparts B and E (2024, as amended), requiring revalidation of all Providers, regardless of Provider types, at least every five (5) years. (See 42 CFR 438.602(b)(1)(2024, as amended))

2.8.2 Provider Credentialing

The Contractor shall:

2.8.2.1 Have a written Credentialing program that complies with 42 CFR 438.12 (2024, as amended) and 42 CFR 438.214 (2024, as amended) and meets all other applicable requirements as stated in this Contract.

2.8.2.1.1 Use a written description of the delegation of Credentialing activities if the Contractor delegates the Credentialing to Subcontractor

2.8.2.1.2 Include within the written description a requirement for the Subcontractor to provide assurance that all licensed medical and/or Behavioral Health professionals are Credentialed in accordance with Department's Credentialing requirements and none of the Network Provider officers or employees have been excluded from participating in a federal or state program.

2.8.2.2 Maintain a Credentialing committee where the Medical Director for the Contractor's Medicaid Managed Care program shall have overall responsibility for the committee's activities. The committee shall have a broad representation from all disciplines (including mid-level practitioners) and reflect a peer review process.

2.8.2.3 Offer Providers the right to review information submitted to support a Credentialing application, to correct erroneous information, receive status of the Credentialing (re-Credentialing) application, and to a non-discriminatory review and receive notification of these rights.

2.8.2.4 Re-Credentialing for Contracted and Non-Contracted Providers shall be completed no less than every three (3) years.

2.8.2.5 Credentialing of Network Providers

The Contractor shall:

2.8.2.5.1 Utilize the current NCQA Standards and Guidelines for the Accreditation of Medicaid Managed Care Organizations for the Credentialing and re-Credentialing of licensed independent Providers and Provider groups

with whom it contracts or employs and who fall within its scope of authority and action.

2.8.2.5.2 Completely process Credentialing applications from all types of Providers within sixty (60) calendar days of receipt of a completed Credentialing application, including all necessary documentation and attachments, and a signed Provider agreement. “Completely process” shall mean that the Contractor shall review, approve, and process approved applicants to its Provider files in its Claims processing system or deny the application and assure that the Provider is not used by the Contractor. At the Contractor’s option, a current South Carolina Medicaid Provider undergoing credentialing may be added to the Provider Network and render services to Members.

2.8.2.5.3 To the extent the Contractor has delegated Credentialing agreements in place with any approved delegated Credentialing entity, the Contractor shall ensure all Providers submitted to the Contractor from the delegated Credentialing entity are processed and loaded into its Claims processing system within sixty (60) calendar days of receipt of the Provider’s roster from the delegated Credentialing entity or the Provider’s completed Credentialing application.

2.8.2.5.4 Notify the Department when the Contractor denies a Provider’s Credentialing application for Program integrity related reasons or otherwise limits the ability of a Provider to serve as an In Network Provider for Program integrity reasons.

2.8.2.6 Credentialing of Non-Network Providers

The Contractor shall:

2.8.2.6.1 Utilize the current NCQA Standards and Guidelines for the Accreditation of Medicaid Managed Care Organizations for the Credentialing and re-Credentialing of licensed independent Providers with whom it does not contract but with whom it has an independent relationship. An independent relationship exists when the Contractor selects and directs its Members to see a specific Provider or group of Providers.

2.8.2.6.2 Completely process Credentialing applications within sixty (60) days of receipt of a completed Credentialing application, including all necessary documentation and attachments, and a signed agreement if applicable. “Completely process” shall mean that the Contractor shall review, approve, and load approved applicants to its Provider files in its Claims processing system or deny the application and assure that the Provider is not used by the Contractor.

2.8.2.6.3 Notify the Department when the Contractor denies a Provider’s Credentialing application for Program integrity related reasons or

otherwise limits the ability of Providers to serve as a Network Provider for Program integrity reasons.

2.8.3 Centralized Provider Enrollment and Credentialing

The Department may partner with external entities for the purpose of centralizing all South Carolina Medicaid Network Provider enrollments and Credentialing functions. These functions include, but are not limited to, receiving completed applications, attestations, and primary source verification documents, and conducting annual Provider site visits to ensure compliance with Medicaid requirements.

Once the Department signs a contract with an entity, the Contractor will receive notice and be required to make said entity responsible for its Credentialing and re-Credentialing process within one hundred and twenty (120) days of notice from the Department.

The Contractor shall:

2.8.3.1 Continue to be responsible for required Credentialing activities throughout the transition to a centralized entity or entities.

2.8.3.2 Have Procedures for informing Network Providers of identified deficiencies, conducting ongoing monitoring of corrective actions, and taking appropriate follow-up actions, such as instituting progressive sanctions and Provider Dispute processes.

2.8.3.3 Conduct reassessments to determine if corrective action yields intended results.

Section 3. MEMBER ELIGIBILITY AND ENROLLMENT

The South Carolina Healthy Connections Program (a.k.a. the South Carolina Medicaid Managed Care Program) is administered by the South Carolina Department of Health and Human Services (SCDHHS) under the 1932(a) State Plan Authority (SSA Sec. 1932. [42 U.S.C. 1396u–2] State Option to Use Managed Care).

3.1 Member Eligibility

Member Enrollment for the South Carolina Healthy Connections Program is governed by the approved State Plan in accordance with federal requirements and state law and policy. Enrollment is limited to certain Medicaid Members who:

3.1.1 Do not have Medicare.

3.1.2 Are under the age of 65.

3.1.3 Are not already eligible for nursing home care.

3.1.4 Are not in a limited benefit eligibility category.

3.1.5 Are not participating in a Home and Community Based waiver Program.

3.1.6 Are not participating in Hospice.

3.1.7 Are not participating in the Program for All Inclusive Care (PACE) Program

3.1.8 Do not have HMO third party coverage.

3.1.9 Are not otherwise excluded from participation based on federal requirements or state laws or Policies.

3.2 Member Enrollment

The Department is solely responsible for the Enrollment of Beneficiaries and Members into the Healthy Connections Program. The Department shall use its best efforts to ensure that the Contractor receives timely and accurate Enrollment and Disenrollment information. In the event of discrepancies or unresolvable differences between the Department and the Contractor regarding Enrollment, Disenrollment and/or termination, the Department will be responsible for taking the appropriate action for resolution.

3.2.1 The Department shall suspend affected Managed Care Enrollments should the Contractor's enrollment percentage reach fifty percent or more (>50%) of the total statewide Managed Care population. If the Contractor meets this condition, the suspension of affected Enrollments shall be for a six- month period. The Contractor will not be allowed additional affected Enrollments until its percentage of total statewide membership is less than fifty percent (<50%) of the statewide Managed Care population at the end of any six-month evaluation period.

3.3 Member Enrollment Process

The Department has established an Enrollment process for the Medicaid Managed Care Program with a third-party Enrollment broker, called South Carolina Healthy Connections Choices (SCHCC). SCHCC is responsible for all Enrollment and Disenrollment activities for potential and enrolled Members, in

accordance with 42 CFR 438.10(b) (2024, as amended). Additional details can be found on the SCHCC website (www.scchoices.com).

The Contractor shall:

3.3.1 Not enroll or Disenroll potential Members. This applies to the Contractor, its employees, agents and/or Subcontractors.

3.3.2 Receive a notification from the Enrollment broker at specified times each month of the Members that are: (a) enrolled, (b) re-enrolled, or (c) Disenrolled from the Contractor's Health Plan. This notification is delivered by the Enrollment broker through electronic media in the 834 file provided by the Enrollment broker. See the Managed Care Report Companion Guide for record layout.

3.3.3 Accept Members in the order in which the Enrollment broker submits them, without restriction (See 42 CFR 438.3 (d)(1) (2024, as amended)) up to the limits authorized by the Department and consistent with the processes specified in this Contract.

3.3.3.1 Potential Members that are designated as "assignable" shall be Enrolled through the following methodology:

3.3.3.1.1 The Member may contact the Enrollment broker and choose the Contractor, at which point the broker will Enroll the Member into the Contractor's health plan so long as the Contractor is available in the Member's county of residence. The Enrollment will be effective on the first day of the next available Enrollment period.

3.3.3.1.2 Members that do not choose a Managed Care health plan, but either (1) have immediate family members Enrolled with the Contractor or (2) have been previously Enrolled with the Contractor in the past seventy-five (75) to ninety (90) days (or three Enrollment periods), will be assigned to that Contractor if available in the Member's county of residence.

3.3.3.2 Current or newly enrolled Medicaid Members that have the choice option to be enrolled with a Managed Care Plan may enroll at any time.

3.3.4 Accept the Department's use of an auto-assignment algorithm for Members that do not select a Contractor's Health Plan. The auto-assignment algorithm is designed to consider factors associated with the Contractor's Health Plan Quality and performance measures and its size and ability to optimally serve its Members under the conditions of this Contract.

3.3.5 Not discriminate against Members on the basis of their health history, health status, need for health care services or adverse change in health status. (See 42 CFR 438.3(d)(3) (2024, as amended))

3.3.6 Not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that

has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability. (See 42 CFR 438.3(d)(4) (2024, as amended))

3.3.7 Quality Weighted Assignment

The Contractor shall accept the Department's Quality weighted assignment algorithm used to assign Members that are not Enrolled through one of the processes described above.

3.3.7.1 The Department shall assign the Quality Weighted Assignment Factor based on the Contractor's South Carolina overall rating for NCQA's Medicaid Health Insurance Plan Ratings, as of November 1st of the preceding year (barring NCQA COVID related assessment modifications).

3.3.7.2 The Contractor's Quality Weighted Assignment Factor shall be updated annually, effective for assignments beginning January 1st. Quality Weighted Assignment Factors are assigned as shown in the chart below.

Quality Weighted Assignment Chart

MCO Health Insurance Plan Rating	**Quality Weighted Assignment Factor**
1.0 or 1.5	0
2	0.5
2.5	0.75
3	1.0
3.5	1.25
4	1.5
4.5	1.75
5	2

3.3.7.3 In the case in which the Contractor does not produce a South Carolina overall rating published in the latest edition of NCQA's Medicaid Health Insurance Plan Ratings, as of November 1st of the preceding year, the Contractor shall be assigned a rating equal to the mode of the overall ratings of the Managed Care Organizations in the latest edition.

3.3.7.3.1 If there are multiple modes, the median of the overall rating shall be used instead.

3.3.7.3.2 If the rating when utilizing either the median or mode of all South Carolina plans results in a value not represented in the Quality Weighted Assignment Chart, then the rating will be rounded down to the nearest rating that is reflected on the Quality Weighted Assignment Chart, and

the Contractor shall be assigned the corresponding Quality Weighted Assignment Factor.

3.3.7.3.3 Should the Contractor receive a rating of "Partial Data Reported" or "No Data Reported", the Contractor shall be assigned a Quality weighted assignment factor of zero (0) unless that rating was applied due to the Contractor's lack of time in the South Carolina Medicaid market.

3.4 Member Enrollment Effective Date

The effective date of Enrollment will be the beginning of the month for new Members specified on the 834 file unless stated otherwise by the Department Member Enrollment period.

The Member shall be enrolled for a period of twelve (12) months or until the next open Enrollment period, contingent upon continued Medicaid eligibility.

3.4.1 Following their initial Enrollment into Contractor's Health Plan, Members have ninety (90) Days from Enrollment in which they may change Health Plans for any reason.

3.4.2 After the initial ninety (90) day period, Members shall remain enrolled in the Contractor's Health Plan for the remaining nine (9) additional months from the effective date of Enrollment or until the next annual open Enrollment period, unless Disenrolled for cause or the Member becomes ineligible for Enrollment in a Managed Care Program.

3.5 Member Annual Re-Enrollment Offer

3.5.1 Annually, the Department or its designees will mail an annual re-Enrollment offer to Members.

3.5.2 If the Member has not chosen another Contractor's Health Plan by the time of his/her anniversary date, the Member will remain with the current Contractor's Health Plan. Members will have ninety (90) days from the anniversary date to determine if they wish to continue to be enrolled with the Contractor's Health Plan.

3.5.2.1 The member may choose a new Health Plan once during the ninety (90) day choice period. (See 42 CFR 438.56(c)(2)(i) (2024, as amended).

3.6 Additional Requirements for Specific Populations

3.6.1 Enrollment of Newborns

To ensure Continuity of Care in the first months of the Newborn's life, every effort shall be made by the Department to expedite Enrollment of Newborns into the same MCO as the mother.

3.6.1.1 Newborns linked to a mother that is Enrolled with the Contractor shall be systemically Enrolled retroactive to their birth month into the Contractor's Health Plan if all the following exist:

3.6.1.1.1 The Newborn was linked to an Enrolled mother in the Medicaid eligibility system at the time the Newborn eligibility transaction was initially sent to the Enrollment broker.

3.6.1.1.2 The Newborn eligibility transaction has initially been sent to the Enrollment broker during the first three (3) months of the Newborn's life.

3.6.1.1.3 Newborns that do not meet the above criteria shall be sent to the Enrollment broker for Enrollment processing. Those Newborns whose guardian choose the Contractor shall be Enrolled with the Contractor at the beginning of the next available Enrollment period. Newborns, whose guardian have not chosen the Contractor by the Enrollment deadline specified by the Enrollment broker shall be auto-assigned to a Managed Care health plan effective at the beginning of the next available Enrollment period.

3.6.1.2 The Contractor shall comply with S. C. Code Ann. §38-71-140 (2015, as amended) pertaining to coverage for Newborns and children for whom adoption proceedings have been instituted or completed. The Department will be responsible for paying the required Capitation Payment only for children who are Members.

3.6.1.3 The Contractor shall reimburse the Department for any Claims that the Department pays for Core Benefits rendered to Newborns during any month that the Contractor received a Capitation Payment for the Newborn.

3.6.2 Enrollment of American Indians

If the Contractor is an Indian Managed Care Entity (IMCE), the CONTRACTOR may restrict Enrollment of American Indians in the same manner as Indian Health Programs may restrict the delivery of services to American Indians, without being in violation of the requirements of 42 CFR 432.3(d) (2024, as amended) and 42 CFR 438.14(d) (2024, as amended).

3.7 Reenrollment

The Department's Enrollment broker will automatically reenroll into the same plan, a previously enrolled Member who was Disenrolled solely because he or she lost Medicaid eligibility for a period of two (2) months or less under42 CFR 438.56(g) (2024, as amended).

3.8 Member Eligibility Redetermination

In an effort to minimize the number of Disenrollments due to loss of Medicaid eligibility, the Department will provide the Contractor with a monthly listing of its Members who were mailed an eligibility Redetermination/Review Form during the month. The term Redetermination shall be used interchangeably with renewal of eligibility.

The Contractor may:

3.8.1 Use the Redetermination notice information to inform the Member of the need to complete and provide the information necessary for the Redetermination.

3.8.2 Use the Redetermination file information to assist its Members in taking appropriate action to complete the necessary information for a Redetermination.

3.8.3 Actions that are permitted with the Members found on the Redetermination files include, but are not limited to:

3.8.3.1 Mail or give the Member copies of the annual review form if the Member indicates that he/she did not receive the original;

3.8.3.2 Meet with the Member to help complete required forms;

3.8.3.3 Provide the Member stamped envelopes, or collect and mail completed forms on behalf of the Member;

3.8.3.4 Address a Member listed on the Redetermination file via phone calls, mailings, text messages or emails using address information from the Department or provided directly by the Member to the Contractor only if the Department has approved the message content.

3.8.3.4.1 If utilizing the text messaging option, the Contractor may send a maximum of one initial opt in text message to Members annually.

3.8.3.5 Notify a Member's Primary Care Provider that the Member needs to renew their Medicaid eligibility.

The Contractor shall:

3.8.4 Permit a Member of a household with multiple persons in that household covered by the Contractor to submit information for those other Members with his/her review form, even if the other Members were not listed on the review form.

3.8.5 Only outreach to Members from the monthly Redetermination file no later than seventy-five (75) days after their planned disenrollment date for the sole purpose of encouraging the Member to complete their Enrollment package and submit it to the Department for processing if they have not already done so.

3.8.6 Not discuss Enrollment or transfers with the Member.

3.8.7 Encourage the Member to contact the SCDHHS Member Services call center at 1-888-549-0820 for further assistance.

3.9 Suspension and/or Discontinuation of Enrollment

3.9.1 Suspension of Enrollment

The Department may suspend new Enrollment and/or auto assignment when the Department has imposed a sanction, or the CONTRACTOR is placed under a Corrective Action Plan in accordance with *Section 18*.

3.9.2 Discontinuation of Enrollment

The Department will discontinue all Enrollments into a CONTRACTOR's Health Plan that has provided notice to terminate the contract in accordance with *Section 17* of this contract.

3.9.2.1 The Department shall discontinue all Enrollments on the date of the notice submitted by the CONTRACTOR or on the earliest possible date by which such Enrollments can be discontinued.

3.9.3 Requests to Discontinue Enrollment

Requests to discontinue receiving Member Enrollment is subject to approval by the Department and any approval will result in the discontinuation of affected Enrollments in the CONTRACTOR's Health Plan, including but not limited to new Members and Member reinstatements.

The CONTRACTOR shall:

3.9.3.1 Submit a request in writing at least sixty (60) Days in advance when the CONTRACTOR has not reached its maximum Enrollment limit.

3.9.3.2 Ensure the request contains the effective period of the request.

3.9.3.3 Ensure the request includes the reason for the request.

3.9.3.4 The CONTRACTOR will pay any costs or charges incurred by the Department, or its Enrollment broker, as a result of a request to discontinue Enrollment.

3.9.4 Requests to Reinstate Enrollment

A request to reinstate enrollment by the CONTRACTOR after a previous request to discontinue receiving Member Enrollment is subject to approval by the Department.

The CONTRACTOR shall:

3.9.4.1 Submit a request in writing at least sixty (60) Days in advance of when the CONTRACTOR desires the reinstatement of Enrollments and has not reached maximum Enrollment.

3.9.4.2 Ensure the request contains the effective period of the request.

3.9.4.3 Ensure the request includes the reason for the request.

3.9.4.4 The CONTRACTOR will pay any costs or charges incurred by the Department, or its Enrollment broker, as a result of a request to reinstate member Enrollment.

3.10 Member Disenrollment

Disenrollments may be initiated by: (1) the Member, (2) the Department, or (3) the CONTRACTOR. (See 42 CFR § 438.56)

A Member may be Disenrolled from the CONTRACTOR's Health Plan only when authorized by the Department. The Department or its designee is responsible for any Disenrollment action to remove a Member from the CONTRACTOR's Health Plan.

3.10.1 Member Disenrollment Requests

A Member (or his or her Representative) may request Disenrollment through oral or written notice from the CONTRACTOR's Health Plan to the Department or its designee (1) for cause at any time, or (2) without cause for the reasons listed in this Section of the contract and in accordance with 42 CFR § 438.56(b)(1)

3.10.1.1 All Member requests for Disenrollment must be referred to the Department or its designee. (See 42 CFR § 438.56(d)(3)(i))

3.10.1.2 The effective date of an approved Disenrollment request must be no later than the first day of the second month following the month in which the Member filed the request or the Contractor refers the request to the Department, whichever is sooner. (See 42 CFR 438.56 and 42 CFR 438.3(q))

3.10.1.3 A Member's request to Disenroll must be acted on by the Department no later than the first day of the second month following the month in which the Member filed the request. If not, the request shall be considered approved. (See 42 CFR 438.56 and 42 CFR 438.3(q))

3.10.1.4 Disenrollment Requests For Cause

A Member may request Disenrollment from the CONTRACTOR's Health Plan for cause at any time as described in 42 CFR § 438.56(d)(2).

3.10.1.4.1 The following are considered acceptable for-cause Disenrollments:

3.10.1.4.1.1 Change in Member Residence

The Member moves out of the CONTRACTOR's Service Area,

3.10.1.4.1.2 Contract Termination

The CONTRACTOR or the Department has terminated the contract,

3.10.1.4.1.3 The member is in need of related services (for example, a Cesarean Section and a tubal ligation) to be performed at the same time; not all related services are available within the Provider network; and the Enrollee's primary care Provider or another Provider determines that receiving the services separately would subject the Enrollee to unnecessary risk.

3.10.1.4.1.4 For Members that use Managed Long Term Care Support Services (MLTSS), the Enrollee would have to change their residential, institutional, or employment supports Provider based on that Provider's change in status from an in-network to an out-of-network Provider with the CONTRACTOR.

3.10.1.4.1.5 Members may Disenroll without cause if the Plan does not, because of moral or religious objections, cover the service the Enrollee seeks.

3.10.1.4.1.6 Other Acceptable Reasons

Other reasons, as approved by the Department on a case-by-case basis, including, but not limited to: (a) poor quality of care; (b) lack of access to Core Benefits; or (c) lack of access to Providers experienced in dealing with the Member's health care needs.

3.10.1.4.2 For cause Disenrollment requests must be initiated by the Member (or his or her representative) with the Enrollment Broker, who will send the appropriate form to the Member for completion.

3.10.1.4.3 The Member is required to contact the Health Plan prior to submitting the completed form to the Enrollment Broker for initial processing.

3.10.1.4.4 Once the Contractor receives notification of the Member's request for disenrollment for cause, the Contractor shall make documented outreach attempts to the Member as follows:

3.10.1.4.4.1 The CONTRACTOR shall make a minimum of three (3) outreach calls to the Member.

3.10.1.4.4.1.1 Each call shall be made on separate days and at different times of day (e.g., morning, afternoon, evening) to ensure reasonable attempts to contact the Member have been made.

3.10.1.4.4.1.2 If the Member's disenrollment for cause request is delineated as urgent on the request form, the Contractor shall complete all required outreach attempts within three (3) Business days.

3.10.1.4.4.1.3 If the Member's disenrollment for cause request is not delineated as urgent on the request form, the Contractor shall complete all required outreach attempts within ten (10) Business days.

3.10.1.4.4.2 All outreach attempts must be clearly documented, including date, time, phone number used, and call outcome.

3.10.1.4.4.3 In cases where the Member is unreachable, the Contractor must also mail a written notice advising the Member of the reason for the attempted contact and provide instructions on how to respond or request assistance.

3.10.1.4.4.3.1 The written notice shall be mailed within the required timeframes for urgent and non-urgent disenrollment for cause outreach attempts as defined in this section of the Contract.

3.10.1.4.4.4 Any outreach attempts must be completed and submitted along with the for-cause disenrollment documentation to the Department for review and approval.

3.10.1.4.5 All Disenrollment for cause decisions are made by the Department or its designee.

3.10.1.4.6 The Member shall have the right to utilize their Grievance and Appeal rights for any adverse decision.

3.10.1.5 Member Disenrollment Requests Without Cause

A Member may request Disenrollment from the CONTRACTOR's Health Plan without cause. The Department will only grant Disenrollment without cause for the following reasons in accordance with 42 CFR § 438.56(c)(2):

3.10.1.5.1 The request is received within ninety (90) Days after the Member's initial Enrollment in a CONTRACTOR's Health Plan or during the ninety 90 days following the date the Department or its designee sends the notice of enrollment, whichever is later.

3.10.1.5.2 Upon automatic reinstatement into a Health Plan if the Member regained Medicaid eligibility within sixty (60) Days.

3.10.1.5.3 At least once every twelve (12) months after initial Enrollment;

3.10.1.5.4 Upon reenrollment if a temporary loss of Enrollment has caused the Member to miss the annual Disenrollment opportunity;

3.10.1.5.5 When the Department imposes an intermediate sanction specified in 42 CFR § 438.702(a)(4) and *Section 18* of this contract.

3.10.2 CONTRACTOR Disenrollment Requests

The CONTRACTOR:

3.10.2.1 May request Member Disenrollment for the following reasons in accordance with 42 CFR § 438.56 (b)(1):

3.10.2.1.1 The CONTRACTOR terminates the contract with the Department;

3.10.2.1.2 The CONTRACTOR discontinues operations within the Member's Service Area;

3.10.2.1.3 The Member dies;

3.10.2.1.4 The Member becomes an Inmate of a public institution;

3.10.2.1.5 The Member moves out of state or the CONTRACTOR's Service Area;

3.10.2.1.6 The Member elects hospice;

3.10.2.1.7 The Member becomes Medicaid Eligible for institutionalization in a LTC Facility/Nursing Home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for more than ninety (90) consecutive Days;

3.10.2.1.8 The Member elects a Home and Community-Based Services (HCBS) waiver program;

3.10.2.1.9 The Member becomes age 65 or older;

3.10.2.1.10 The Member's continued Enrollment in the CONTRACTOR's Health Plan seriously impairs the CONTRACTOR's ability to furnish services to either this particular Member or other Members.

3.10.2.2 Shall submit the request in writing to the Department's Enrollment Broker. The Contractor shall:

3.10.2.2.1 Include sufficient detail regarding the reason for Disenrollment. The Enrollment Broker will log this request and forward it to the Department for review and approval/disapproval.

3.10.2.2.2 Provide additional information and documentation to the Department if the Department requests such information.

3.10.2.2.3 Complete a Health Plan Initiated Member Disenrollment Form within the timeframe as outlined in this contract. More information regarding the Health Plan-Initiated Member Disenrollment Form may be found in the Managed Care Report Companion Guide.

3.10.2.3 May not request Disenrollment for the following reasons under 42 CFR § 438.56(b)(2):

3.10.2.3.1 An adverse change in the Member's health status,

3.10.2.3.2 The Member's utilization of medical services,

3.10.2.3.3 The Member's diminished mental capacity, or

3.10.2.3.4 The Member's uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to the Member or other Members).

3.10.2.4 Shall immediately notify the Department when it obtains knowledge of any Member who is no longer eligible for Enrollment in a Health Plan.

3.10.2.5 At the Department's request, shall specify the methods by which it assures the Department that it does not request Disenrollment for reasons other than those permitted under the contract as specified in42 CFR § 438.56(b)(3).

3.11 Member Rights

The CONTRACTOR shall:

3.11.1 Have written Policies guaranteeing each Member's rights.

3.11.2 Make available to Members both oral and written information about the nature and extent of their rights and responsibilities as Members of the CONTRACTOR.

3.11.3 Ensure that staff and affiliated Providers observe and protect the Member's right when furnishing services.

3.11.4 Ensure the following Member Rights in accordance with 42 CFR § 438.100(b)):

3.11.4.1 To be treated with respect and with due consideration for dignity and privacy;

3.11.4.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand and participate in decisions regarding healthcare, including the right to refuse treatment;

3.11.4.3 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in the federal regulations on the use of restraints and seclusion; and

3.11.4.4 To be able to request and receive a copy of the Member's Health Records, and request that they be amended or corrected as specified in 45 CFR §164.

3.11.4.5 The CONTRACTOR must make a good faith effort to give written notice of termination of a contracted provider to each Member who received his or her primary care from or was seen on a regular basis by the terminated provider. Notice to the Member must be provided by the later of thirty (30) Calendar Days prior to the effective date of the termination, or fifteen (15) Calendar Days after receipt or issuance of the termination notice. (42 CFR § 438.10(f)(1))

3.11.4.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the CONTRACTOR and its Providers, or the Department, treat the Medicaid Managed Care Member.

3.11.4.6.1 Information regarding the Medicaid Member's right to obtain available and accessible health care services covered under the contract. (42 CFR § 438.10(g)(2)(ix); 42 CFR § 438.100(b)(3))

3.12 Member Responsibilities

The Member's responsibilities shall include, but are not limited to:

3.12.1 Inform the CONTRACTOR of the loss or theft of ID cards,

3.12.2 Present ID cards when using health care services,

3.12.3 Be familiar with the CONTRACTOR's Health Plan Procedures to the best of their abilities,

3.12.4 Call or contact the CONTRACTOR to obtain information and have questions clarified,

3.12.5 Provide participating network Providers with accurate and complete medical information,

3.12.6 Follow the prescribed course of care recommended by the Provider or let the Provider know the reasons the treatment cannot be followed, as soon as possible,

And

3.12.7 Make every effort to keep a scheduled appointment or cancel an appointment in advance of when it is scheduled.

3.13 Member Call Center

The CONTRACTOR shall maintain an organized, integrated Medicaid Managed Care Member services call-in center that provides a toll-free number, physically located in the United States equipped with caller identification, automatic call distribution equipment capable of handling the expected volume of calls, with dedicated staff to respond to member questions.

3.13.1 The Member Call Center should be able to respond to questions that include, but are not limited to, such topics as:

3.13.1.1 Information regarding Primary Care Provider (PCP) selection including registering the Medicaid Managed Care Member's choice,

3.13.1.2 Explanation of CONTRACTOR Policies and Procedures,

3.13.1.3 Information regarding Prior Authorization requirements,

3.13.1.4 Information regarding Covered Services,

3.13.1.5 Information on Primary Care Providers (PCPs) or specialists,

3.13.1.6 Referral process to participating specialists,

3.13.1.7 Resolution of service and/or medical delivery problems,

3.13.1.8 Questions and/or referral requests resulting from the placement of the Member in the State's Pharmacy Lock-in Program (SPLIP),

3.13.1.9 Member Grievances,

3.13.1.10 Call Center Availability and Operation

3.13.2 Toll-Free Number

3.13.2.1 The toll-free number shall be staffed between the hours of 8:00 a.m. through 6:00 p.m. Eastern Time, Monday through Friday, excluding state declared holidays. The toll-free line shall have an automated system, available twenty-four (24) hours a day, and seven (7) Days a week.

3.13.2.1.1 This automated system shall include the capability of providing callers with instructions on what to do in case of an emergency and the option to

talk directly to a nurse or other clinician or leave a message, including instructions on how to leave a message and when that message will be returned.

3.13.3 Telephone Lines

The CONTRACTOR shall have sufficient telephone lines to answer incoming calls.

3.13.4 Staffing

The CONTRACTOR shall ensure sufficient staffing of the call center adjusted for peak call-volume time.

3.13.4.1 The Department reserves the right to enact any or all corrective measures defined in this contract.

3.13.5 Telephone Help Line Policies and Procedures

The CONTRACTOR shall:

3.13.5.1 Develop telephone help line Policies and Procedures that address staffing, personnel, hours of operation, access, and response standards, monitoring of calls via recording or other means, and compliance with standards.

3.13.5.2 Make the Policies and Procedures available to the Department for review.

3.13.5.3 Ensure inquiries from Members can be routed to the appropriate resources not limited to the Contractor's internal system but externally to the Department, and others.

3.13.6 Non-English-Speaking Services

The CONTRACTOR shall ensure that translation services are available for all non- English-speaking callers.

3.13.7 Automated Call Distribution (ACD) System

The CONTRACTOR shall install, operate, and monitor an Automated Call Distribution (ACD) system for the customer service telephone call center. The ACD system shall:

3.13.7.1 Effectively manage all calls received and assign incoming calls to available staff in an efficient manner;

3.13.7.2 Transfer calls to other telephone lines;

3.13.7.3 Provide detailed analysis as required for the reporting requirements, as specified, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume;

3.13.7.4 Provide a message that notifies callers that the call may be monitored for quality control purposes;

3.13.7.5 Measure the number of calls in the queue at peak times;

3.13.7.6 Measure the length of time callers are on hold;

3.13.7.7 Measure the total number of calls and average calls handled per Day/week/month;

3.13.7.8 Measure the average hours of use per Day;

3.13.7.9 Assess the busiest times and Days by number of calls;

3.13.7.10 Record calls to assess whether answered accurately;

3.13.7.11 Provide a backup telephone system that shall operate in the event of line trouble, emergency situations including natural disasters, or other problems so that access to the telephone lines are not disrupted;

3.13.7.12 Provide Interactive Voice Response (IVR) options that are user- friendly to members and include a decision tree illustrating the IVR system; and

3.13.7.13 Inform the member to dial 911 if there is an emergency.

3.13.8 Call Center Performance Standards

The CONTRACTOR shall maintain member call center metrics at the following levels, measured on a monthly basis, for Call Center Performance Standards:

3.13.8.1 An average of eighty (80) percent of incoming calls each month are answered within thirty (30) seconds or the call is directed to an automatic call pickup system with IVR options;

3.13.8.2 The average response time shall equal number of calls picked-up within thirty (30) seconds each month divided by the total calls received each month

3.13.8.3 No more than two (2) percent of incoming calls shall receive a busy signal per day;

3.13.8.4 An average hold time of two (2) minutes or less;

3.13.8.4.1 Hold time or wait time shall include the time a caller spends waiting for assistance from a customer service representative after the caller has navigated the IVR system and requested a live person.

3.13.8.4.2 The Contractor shall ensure that hold time messages do not include non-health related items (e.g., life insurance, disability).

3.13.8.4.3 The Contractor shall submit hold time messages that promote the Contractor or include benefit information to the Department for prior approval.

3.13.8.5 An abandoned rate of calls of not more than five (5) percent;

3.13.8.5.1 The abandoned rate of calls equals the number of calls abandoned each month divided by the total calls received each month.

3.13.8.6 The CONTRACTOR must conduct ongoing quality assurance to ensure these standards are met.

3.13.8.7 If the Department determines it is necessary to conduct onsite monitoring of the CONTRACTOR's call center functions, the CONTRACTOR is responsible for all reasonable costs incurred by Department or its authorized agent(s) relating to such monitoring if the call center is located outside of South Carolina.

3.13.8.8 The CONTRACTOR, including any Subcontractor responsible for call center activity, shall have written Policies regarding member rights and responsibilities.

3.13.8.9 The CONTRACTOR and its Subcontractor shall comply with all applicable state and federal laws pertaining to member rights and privacy.

3.13.8.10 The CONTRACTOR and Subcontractor shall further ensure that the CONTRACTOR's employees, CONTRACTORs, and Providers consider and respect those rights when providing services to members.

3.13.9 If the Contractor fails to comply with the requirements of this provision, the Contractor shall be subject to liquidated damages or sanctions as determined by the Department.

3.13.10 The Contractor agrees to relinquish ownership of the toll-free numbers upon contract termination, at which time the Department may take title to these telephone numbers.

3.13.11 The Contractor agrees that all phone charges incurred during the contract period are the sole obligation of the Contractor.

3.14 Cultural Competency

As required by 42 CFR § 438.206, the CONTRACTOR shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

The Contractor shall:

3.14.1 Identify relevant community issues, health promotions, and education needs of its Members and implement plans that are culturally appropriate to meet those identified needs and issues relevant to each of the target population groups of Members served.

3.14.2 Use community-based needs assessments and other relevant information available from State and local governmental agencies and community groups.

3.14.3 The Contractors shall comply with all applicable State and federal statutes, regulations, and protocols on the delivery of culturally-competent health wellness programs.

3.15 Advance Directives

3.15.1 The Contractor shall maintain written policies and procedures on advance directives for all adults receiving care by or through the Contractor. [42 CFR § 438.3(j)(1) and (2); 42 CFR § 422.128(a); 42 CFR § 422.128(b); 42 CFR § 489.102(a)]

3.15.2 The Contractor shall educate staff concerning their policies and procedures on advance directives. [42 CFR § 438.3(j)(1) and (2); 42 CFR § 422.128(b)(1)(ii)(H); 42 CFR § 489.102(a)(5)]

Section 4. CORE BENEFITS AND SERVICES

The CONTRACTOR shall cover the physical health and Behavioral Health Services outlined within this Section of this contract.

Managed Care Coverage			
Service Category	**Carved in**	**Carved Out**	**Comment**
Ambulance	✓		
Ancillary Medical Services	✓		
Audiological Services	✓		
Autism Spectrum Disorder (ASD) Services	✓		
Behavioral Health and Outpatient Services	✓		
Chiropractic Care	✓		
Community Long Term Care Waiver Services		✓	
Communicable Disease Services	✓		
Dental Services		✓	
Developmental Evaluation Centers	✓		
Durable Medical Equipment	✓		
Early Intervention Services		✓	
EPSDT	✓		
Emergency and Post Stabilization Services	✓		
Family Planning	✓		
Home Health Services	✓		
Hysterectomies	✓		
Independent Laboratory and X-Ray Services	✓		
Inpatient Hospital Services	✓		
Institutional Long-Term Care Facilities/Nursing Facilities			90 Days appx
Maternity Services	✓		
Outpatient Services	✓		
Pharmacy	✓		
Physician Services	✓		
Rehabilitative Therapies for Children	✓		
Sterilization	✓		
Substance Abuse	✓		
Targeted Case Management			Referral Assistance
Transplant and Transplant Related Services	✓		
Vaccine Services	✓		
Vision Care Exams	✓		

4.1 General Core Benefits and Services Requirements

Core Benefits shall be available to each Medicaid Managed Care Member within the CONTRACTOR's Service Area. The CONTRACTOR shall provide Core Benefits and services to Members, pursuant to the provisions of this contract.

The CONTRACTOR shall:

4.1.1 Implement Procedures to coordinate the delivery of physical health, Behavioral Health, and long-term care services that it furnishes with services the member receives from any other entity.

4.1.2 Furnish Core Benefits and services in accordance with Medical Necessity and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries and for beneficiaries under the age of 21 up to the limits as specified in the Medicaid FFS Program as defined in the State Plan, administrative rule and Department Process and Procedure Manual and all applicable federal and state statues, rule, and regulations. (42 CFR § 438.210(a)(2))

4.1.3 Follow any modified version of a Core Benefit and/or service under the Medicaid FFS Program—the amount, duration and/or scope of services— unless otherwise exempted by the Department.

4.1.4 Honor and pay for Core Benefits and services for new Members or when a new Benefit/service is added as a Core Benefit/service.

4.1.5 Ensure that services are covered in accordance with 42 CFR § 438.210, as follows:

4.1.5.1 Shall ensure that services are sufficient in amount, duration, and scope to achieve the purpose for which the services are furnished. (42 CFR § 438.210(a)(3)(i))

4.1.5.2 May not arbitrarily deny or reduce the amount, duration, or scope of a required service because of diagnosis, type of illness, or condition of the Member.

4.1.5.3 The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Enrollee’s ongoing need for such services and supports. (42 CFR § 438.210(a)(3)(ii); 42 CFR § 438.210(a)(4)(ii)(B))

4.1.5.4 Family Planning Services are provided in a manner that protects and enables the Enrollee’s freedom to choose the method of Family Planning to be used consistent with 42 CFR §441.210(a)(4)(ii)(C)

4.1.5.5 May place appropriate limits on a service in accordance 42 CFR § 438.210(a)(4)(i) :

4.1.5.5.1 On the basis of certain criteria, such as Medical Necessity,

Or,

4.1.5.5.2 For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose. (42 CFR § 438.210(a)(4)(ii)(A))

4.1.6 Not condition the provision of services or otherwise discriminate against a Medicaid Managed Care Member based on whether or not the individual has executed an advance directive. (42 CFR § 438.3(j)(1) and (2); 42 CFR § 422.128(b)(1)(ii)(H); 42 CFR § 489.102(a)(5))

4.1.7 Mental Health Parity Requirements

The Contractor shall deliver mental health and substance use disorder benefits in accordance with 42 CFR § 438, Subpart K.

4.2 Specific Core Benefits and Services Requirements

4.2.1 Abortions

The CONTRACTOR shall:

4.2.1.1 Ensure abortions are performed in accordance with 42 CFR § 441, Subpart E and the requirements of the Hyde Amendment (Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act, 1998, Public Law 105-78, §§ 509 and 510).

4.2.1.2 Submit a completed abortion statement form and any other documentation reporting requirements as outlined in the Physician Services Provider Manual.

4.2.1.3 Be reimbursed for abortion services only if performed in accordance with all federal, state and Department provisions.

4.2.2 Ambulance Transportation

4.2.2.1 The Contractor shall comply with provisions of the Department's Ambulance Service Manual and other applicable manuals issued by the Department. In no instance may the limitations or exclusions imposed by the CONTRACTOR be more stringent than those specified in the applicable manuals and guide(s).

4.2.2.2 In the event an ambulance is called to a location but not used for transport (i.e., the Member is not taken to a medical services Provider), the Contractor shall maintain responsibility for payment to the Provider.4.2.2.2.1 If the Contractor authorizes out-of-state Referral Services and the Referral Service is available in-state, the Contractor shall be responsible for all Medicaid Covered Services related to the Referral Service to include all modes of transportation, escorts, meals, and lodging.

4.2.2.2.2 If the Contractor authorizes out-of-state services and the service is not available in-state, the Contractor shall be responsible for the cost of Referral Services and any ambulance or medivac transportation.

4.2.3 Ancillary Medical Services

Ancillary medical services are included in the Medicaid Managed Care Program coverage array. These services include, but are not limited to, anesthesiology, pathology, radiology, emergency medicine, inpatient dental facility charges, outpatient dental facility charges, and ambulatory surgical center charges for dental services.

The CONTRACTOR shall:

4.2.3.1 Comply with provisions of the respective service manuals and other applicable manuals and Policies issued by the Department. In no instance may the limitations or exclusions imposed by the CONTRACTOR be more stringent than those specified in the Department's manuals or guide(s).

4.2.3.2 Reimburse these services at the Medicaid fee-for-service rate unless another reimbursement rate has been previously negotiated with the Provider(s) of these services.

4.2.3.3 Not require prior Authorization for these services of either network or Non-Participating Providers.

4.2.4 Audiological Services

Audiological services include diagnostic, screening, preventive, and/or corrective services provided to individuals: (a) with hearing disorders, and (b) for the purpose of determining the existence of a hearing disorder by or under the direction of an Audiologist. A Physician or other licensed practitioner of the healing arts (LPHA), within the scope of his or her practice under state law, must refer individuals to receive these services.

The CONTRACTOR shall:

4.2.4.1 Be responsible for providing a range of examinations, fittings, necessary supplies and equipment, and related audiological services.

4.2.4.2 Refer to the specific Medicaid Procedures and limitations listed in the Department's Private Rehabilitative Therapy and Audiological Services Provider manual.

4.2.5 Autism Spectrum Disorder (ASD) Services

Services to treat Autism Spectrum Disorder (ASD) are provided to eligible Medicaid beneficiaries ages 0 to 21. ASD services must be recommended by a Licensed Psychologist, Developmental Pediatrician, or a Licensed Psycho-Educational Specialist (LPES) within his or her scope of practice under the South Carolina State law to prevent the progression of ASD, prolong life, and promote the physical and mental health and efficacy of the individual. These services shall be provided in the Member's home, clinical setting, or other settings as authorized in the applicable section of the SCDHHS Services Provider Manual.

4.2.5.1 Developmental Evaluation Services (DECS)

Developmental Evaluation Services (DECs) are defined as medically necessary comprehensive neurodevelopment and psychological developmental, evaluation and treatment services for Members between the ages of zero (0) to twenty-one (21) years of

age. DEC services are provided for the purpose of facilitating correction or amelioration of physical, emotional and/or mental illnesses, and other conditions, which if left untreated, would negatively impact the health and quality of life of the Member. Pediatric day treatment, when rendered by DECs, is considered as one of the DEC treatment services.

4.2.6 Behavioral Health Services

The CONTRACTOR shall:

4.2.6.1 Ensure the provision of all medically necessary Behavioral Health Services set forth in the Department's Licensed Independent Practitioner Manual, the Physicians, Laboratories, and Other Medical Professionals Provider Manual, the Clinic Services Manual, the Hospital Services Manual, the Rehabilitative Behavioral Health Services Manual, the Community Mental Health Manual, the Autism Manual, and the Psychiatric Hospital Services Manual.

4.2.6.2 Remain in compliance with the Mental Health Parity and Equity Act (MHPEA) as determined by the Department or its designee.

4.2.6.3 Provide medically necessary inpatient psychiatric services in an Institution for Mental Disease (IMD) for members that are diagnosed with mental health and/or substance use disorders from birth to age twenty-one (21).

4.2.6.4 Cover the costs for all Members for psychological assessment/testing, as per the manuals referenced above, if a Member has a diagnosis listed in the current version of the DSM, or if psychological assessment is used to establish a clinically necessary differential diagnosis.

4.2.6.5 The CONTRACTOR may provide services for Members aged twenty one (21) through sixty four (64) receiving inpatient treatment in an Institution for Mental Disease (IMD), so long as the facility is a hospital providing psychiatric or substance use disorder inpatient care or a sub- acute facility providing psychiatric or substance use disorder crisis residential services, the length of stay in the IMD is for a short term stay of no more than fifteen (15) Days during the period of the monthly Capitation Payment. The provision of inpatient psychiatric or substance use disorder treatment in an IMD must meet the requirements for in lieu of services at 42 CFR § 438.3(e)(2)(i) through (iii).

For purposes of rate setting, the Department will include the utilization of services provided to an Enrollee under this Section when developing the substance use disorder component of the capitation rate but will price utilization at the cost of the same services through Providers included under the State Plan.

4.2.6.5.1 The Department shall utilize a premium proration process for any members aged twenty-one (21) through sixty-four (64) receiving inpatient treatment in an IMD in excess of fifteen (15) Days in any month.

4.2.6.5.2 In satisfying Training requirements in *Section 2*, train providers and describe its education strategies in place to reduce the stigma associated with mental health and substance use disorder services.

4.2.6.6 Requirements for Members Receiving Psychiatric Residential Treatment Facility (PRTF) Services

The Contractor shall:

4.2.6.6.1 Honor the existing authorization(s) in place for those Members transferring to the Contractor's health plan while receiving PRTF services until Care Coordination and Case Management can be completed by the Contractor. The Contractor shall assess the Member's need for continuing treatment and the continued stay in the institutional setting.

4.2.6.6.2 Cover the costs of the Member on the day of admission to a PRTF, to include facility and ancillary charges associated with the time the Member remains with the Contractor, if the Member was enrolled with the Contractor at the time of admission.

4.2.6.6.3 In cases where the Member loses Medicaid eligibility entirely, the Contractor shall no longer be responsible for facility charges unless a retroactive eligibility determination re-establishes responsibility for payment.

4.2.7 Chiropractic Services

Chiropractic services are available to all Members. Chiropractic services are limited to manual manipulation of the spine to correct a subluxation. Specific requirements for Medicaid chiropractic services may be found in the Department's Physicians Provider Manual.

The CONTRACTOR shall:

4.2.7.1 Comply with provisions of the respective service manuals and other applicable guides and Policies issued by the Department.

4.2.7.2 Not impose limitations or exclusions more stringent than those specified in the manuals.

4.2.8 Communicable Disease Services

An array of communicable disease services that are available to help control and prevent diseases including but not limited to, Tuberculosis (TB), Syphilis, and other sexually transmitted diseases (STDs) and HIV/AIDS. Communicable disease services include examinations, assessments, diagnostic procedures, health education and counseling, treatment, and contact tracing, according to the Centers for Disease Control and Prevention (CDC) standards. In addition, specialized outreach services are provided such as Directly Observed Therapy (DOT) for TB cases. All Members have the freedom to receive TB, STD and HIV/AIDS testing and counseling services from any public health agency without any restrictions.

The CONTRACTOR shall:

4.2.8.1 Use services available to help control and prevent diseases.

4.2.8.2 Provide communicable disease services for TB.

4.2.8.3 Provide communicable disease services for Sexually Transmitted Diseases (STDs).

4.2.8.4 Provide communicable disease services for Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome (HIV/AIDS) infection.

4.2.8.5 Refer, either directly or through its network Provider, suspected and actual TB cases to the Department for clinical management, treatment, and direct observed therapy. The Department provides a range of primary and secondary prevention services through its local health clinics to provide and/or coordinate communicable disease control services. This care shall be coordinated with the Member's In-Network PCP.

4.2.9 Disease Management

Disease management is a collection of medically necessary interventions designed to improve and maintain the health of Members. Disease management includes the coordination, monitoring, and education of Members to maximize appropriate self-management of chronic diseases.

The CONTRACTOR shall:

4.2.9.1 Comply with Physical and Behavioral Health disease management, Case Management, and Care Coordination provisions set forth in *Section 4* and *Section 5* of this contract and other relevant Department manuals and guides.

4.2.10 Durable Medical Equipment (DME)

Durable Medical Equipment (DME) includes equipment and supplies that provide therapeutic benefits and/or enables an individual to perform certain tasks s/he would otherwise be unable to undertake due to certain medical conditions and/or illnesses. DME equipment and supplies are primarily and customarily used for medical reasons—appropriate and suitable for use in the home. The CONTRACTOR shall abide by the relevant Department Provider manuals in providing DME equipment and supplies.

The CONTRACTOR shall:

4.2.10.1 Be responsible for informing Members and In Network Providers of the CONTRACTOR's policy regarding rental and/or purchase of equipment.

4.2.11 Early and Periodic Screening, Diagnosis and Treatment (EPSDT)/Well Child Visits

The CONTRACTOR shall:

4.2.11.1 Have written Policies and Procedures consistent with 42 CFR § 441, Subpart B, for notification, tracking, and follow- up to ensure EPSDT services will be available to all Eligible Members.

4.2.11.2 Be responsible for assuring that children through the month of their 21st birthday are screened and cared for according to the American Academy of Pediatrics (AAP) periodicity schedule. The periodicity schedule is available at the AAP website.

4.2.11.2.1 In accordance with Bright Futures Periodicity Schedule, the Contractor shall not impose any annual limits or cap to the amount of well child visits a member receives.

4.2.12 Emergency and Post Stabilization Services

4.2.12.1 Emergency Services are defined as Inpatient and Outpatient Services necessary to evaluate or stabilize an Emergency Medical Condition furnished by qualified Providers (42 CFR § 438.114). Emergency Services include, but are not limited to: Radiology, Pathology, Emergency Medicine, and Anesthesiology. In accordance with 42 CFR § 438.114(c), the CONTRACTOR shall:

Inpatient and Outpatient Services necessary to evaluate or stabilize an Emergency Medical Condition furnished by qualified Providers (42 CFR § 438.114). In accordance with 42 CFR § 438.114(c), the CONTRACTOR shall:

4.2.12.1.1 Cover and pay for Emergency Services.

4.2.12.1.2 Provide Emergency Services without Prior Authorization.

4.2.12.1.3 Not limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms.

4.2.12.1.4 Promptly pay for Emergency Services regardless of whether the Provider has a contract with the CONTRACTOR consistent with 42 CFR § 438.114(c)(1)(i). Refer to *Section 7* regarding payment for Emergency Services rendered by out-of- network Providers.

4.2.12.1.5 Defer to the attending emergency Physician or the Provider treating the Member for the determination of when the Member is sufficiently stabilized for transfer or discharge from Emergency Services. (42 CFR § 438.114(d)(3))

4.2.12.1.6 Not decline coverage for Emergency Services based on the emergency room Provider, hospital, or fiscal agent not notifying the Member's PCP, CONTRACTOR or applicable state entity of the Member's screening and treatment within ten (10) Calendar Days of presentation for Emergency Services (42 CFR § 438.114(d)(1)(ii)).

4.2.12.1.7 Not decline payment for treatment when a CONTRACTOR representative instructs the Member to seek Emergency Services.

4.2.12.1.8 Not decline payment for treatment obtained when a Member had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not result in placing the health of the

individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part (1932(b)(2); 42 CFR § 438.114(c)(1)(ii)(A); 42 CFR § 438.114(d)(2).

4.2.12.1.9 Not hold the Member with an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. (42 CFR § 438.114(d)(3))

4.2.12.1.10 Advise all Members of the provisions governing in- and out-of-service-area use of Emergency Services.

4.2.12.2 Post Stabilization Services

Benefits and services, related to an Emergency Medical Condition that are provided after a Member is stabilized to maintain the stabilized condition, or, under the circumstances described in this Section, to improve or resolve the Member's condition (42 CFR § 438.114). The Contractor shall cover Post Stabilization Services in accordance with Section 1867 of the Social Security Act, 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(3)(i) - (iv).

The CONTRACTOR shall:

4.2.12.2.1 Cover benefits and services that may be required subsequent to the stabilization of a medical condition without Prior Authorization, including transfer of the individual to another facility.

4.2.12.2.2 Be responsible for payment to Providers— both In-network and out-of-network Service Area(s), without requiring prior approval, in accordance with the Social Security Act Section 1867 (42 U.S.C. § 1395 dd).

4.2.12.2.3 Cover Post Stabilization Services that were not pre-approved by the CONTRACTOR because the CONTRACTOR did not respond to the Provider of Post Stabilization Services request for pre-approval within one (1) hour after the request was made.

4.2.12.2.4 Cover Post- Stabilization Services if the CONTRACTOR could not be contacted for pre-approval.

4.2.12.2.5 Cover Post Stabilization Services if the CONTRACTOR and the treating Provider cannot reach an agreement concerning the Member's care and an In Network Provider is not available for consultation. In this situation, the CONTRACTOR shall give the treating Provider the opportunity to consult with a CONTRACTOR's In Network Provider, and the treating Provider may continue with the care of the Member until a network Provider is reached or one of the criteria of 42 CFR § 422.113(c)(3) is met.

4.2.12.2.6 Limit charges to Members for any Post Stabilization Services to an amount no greater than what the charges would be if the Member had

obtained the services through one of the CONTRACTOR's In Network Providers.

4.2.12.2.7 Transfer of the individual to another medical facility within Social Security Act Section 1867 (42 U.S.C. § 1395 dd) guidelines and other applicable state and federal regulations.

4.2.12.2.8 Be financially responsible for Post Stabilization Services it has not pre-approved until:

4.2.12.2.8.1 A CONTRACTOR's In Network Provider with privileges at the treating hospital assumes responsibility for the Member's care,

4.2.12.2.8.2 A CONTRACTOR's In Network Provider assumes responsibility for the Member's care through transfer,

4.2.12.2.8.3 A CONTRACTOR's representative and the treating Provider reach an agreement concerning the Member's care,

Or,

4.2.12.2.8.4 The Member is discharged.

4.2.13 Family Planning Services

Family Planning Services include traditional contraceptive drugs, supplies, and preventive contraceptive methods. These include, but are not limited to, the following: (1) examinations, (2) assessments, (3) diagnostic procedures, and (4) health education, prevention and counseling services related to alternative birth control and prevention as prescribed and rendered by various Providers. (Section 1902(a)(23) of the Act; 42 CFR § 431.51(b)(2))

The CONTRACTOR:

4.2.13.1 Shall be responsible for reimbursement for Family Planning Services.

4.2.13.2 Shall allow Members the freedom to receive Family Planning Services from an appropriate Provider without restrictions.

4.2.13.3 May encourage but not require Members to receive Family Planning Services through an in-network Provider or by appropriate referral as to promote the integration/coordination of these services.

4.2.14 Home Health Services

Home health services are healthcare services delivered in a person's place of residence, excluding nursing homes and institutions, and include intermittent skilled nursing, home health aide, physical, occupational and speech therapy services, and Physician-ordered supplies. The CONTRACTOR shall comply with 42 CFR § 440.70(b)(3)(v) in the administration of the Home Health benefit.

The CONTRACTOR shall:

4.2.14.1 Effective with the procurement and implementation of the Department's statewide Subcontractor for Electronic Visit Verification, procure a contract with the Department's Electronic Visit Verification Subcontractor and ensure compliance with 12006(a) of the 21st Century Cures Act.

4.2.14.2 Be responsible for providing incontinence supplies to any enrolled Member meeting Medical Necessity criteria for these services.

4.2.14.3 Refer to relevant Department Provider manuals for additional details regarding this Benefit/service coverage requirement.

4.2.15 Hysterectomies

The CONTRACTOR shall:

4.2.15.1 Cover the cost of hysterectomies when they are non-elective and medically necessary as provided in 42 CFR § 441.255 (2010, as amended) and in accordance with all federal and State laws.

4.2.15.2 Ensure non-elective, medically necessary hysterectomies are documented and meet the requirements as outlined in this contract and all applicable Department manuals and guides.

4.2.15.2.1 The Contractor shall maintain original versions of required forms in the Member's Health Record and a copy must be submitted to the Contractor for retention in the event of audit.

4.2.15.2.2 In the event the requesting Physician does not complete and submit the required forms, it is permissible for the Contractor to delay or deny payment until proper completion and submission of the required form(s).

4.2.16 Independent Laboratory and X-Ray Services

The CONTRACTOR shall pay for medically necessary laboratory and X- ray services, including genetic testing services ordered by a Physician and provided by independent laboratories and portable and free-standing x-ray facilities. An independent laboratory and x-ray facility is defined as a facility licensed by the appropriate State authority and not part of a hospital, clinic, or Physician's office. The CONTRACTOR shall abide by the requirements found within applicable Department manuals.

The CONTRACTOR shall:

4.2.16.1 Require that all laboratory testing sites providing services under this contract have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number (42 CFR § 493.1; 42 CFR § 493.3).

4.2.17 Inpatient Hospital Services

Inpatient hospital services are services that are provided under the direction of a Physician and are furnished to a patient who is admitted to an acute care medical facility for a period of time,

as defined in the Department's Hospital Provider Manual. These services may include, but are not limited to, a full range of necessary diagnostic and therapeutic care including surgical, dental, medical, general nursing, radiological and rehabilitative services in emergency or Non-Emergency conditions. Additional inpatient hospital services would include room and board, miscellaneous hospital services, medical supplies, and equipment. The Contractor shall refer to applicable Department Provider manuals for details about services and payment responsibilities based on Enrollment status.

The CONTRACTOR shall:

4.2.17.1 Upon the Member's Day of Admission to a hospital, cover the facility charges associated with the entire stay (admission through discharge). In Cases where the Member loses Medicaid eligibility entirely, the Contractor is no longer responsible for facility charges unless a Redetermination re-establishes Medicaid eligibility and responsibility for payment.

4.2.17.2 Back Transfer Requirements

4.2.17.2.1 The CONTRACTOR shall allow for the transfer of Members from one hospital to another hospital, or from a hospital to a lower level of care, when requested by the Provider. The decision on when and to what level of care a Member is to be transferred is solely that of the attending Physician, including those transfers as it relates to the back transferring of a newborn or infant to their original or lower level healthcare facility. Transfer coordination from point A to point B is initiated by the Provider with CONTRACTOR support upon request, and the CONTRACTOR shall not require prior authorization for the purposes of back transferring the Member.

4.2.18 Institutional Long-Term Care (LTC) Facilities/Nursing Facilities (NFs)

LTC Facilities/NF are those services provided in a facility that is licensed as a nursing facility or hospital that provides swing bed or Administrative Days. Administrative Days are counted as part of the hospital stay and do not count towards fulfilling the Contractor's long-term care responsibility. Hospital Swing Beds are counted in the same way as nursing home days and do count towards fulfilling the Contractor's responsibility for long-term care.

The CONTRACTOR shall:

4.2.18.1 Ensure admission procedures of the Member adhere to the Medicaid requirements of participation for nursing facilities, including level of care certification, preadmission screening and resident review (PASARR), resident assessment, notification of patient's rights, and other responsibilities.

4.2.18.2 Obtain the level of care certification (DHHS Form 185 and/or DHHS Form 185S) from the Department, the social worker, or the nursing facility for a Member upon admission to the facility. The CONTRACTOR shall implement the level of care certification as identified on the DHHS certification form.

4.2.18.3 Request a copy of the Notice of Admission, Authorization and Change of Status for LTC (DHHS Form 181) from the nursing facility.

4.2.18.4 Be responsible for LTC until the Member can be Disenrolled at the earliest effective date allowed by the Department's Medicaid eligibility system, at which time payment for Institutional LTC services will be reimbursed FFS by the Medicaid Program.

4.2.18.5 Reimburse LTC facilities that provide Hospital Swing Beds or Administrative Days if the CONTRACTOR's Member(s) qualify for LTC placement.

4.2.18.6 Work in conjunction with the Department to ensure timely identification of persons certified to enter long-term care facilities/nursing homes.

4.2.19 Maternity Services

Maternity care benefits and services include prenatal, delivery, postpartum services and nursery charges for a normal pregnancy or complications related to the pregnancy.

The CONTRACTOR shall:

4.2.19.1 Ensure all Members and their infants receive risk appropriate medical and Referral Services.

4.2.19.2 Be responsible for inpatient hospital Claims billed on the facility claim form that include both a Cesarean Section and sterilization.

4.2.19.3 Be responsible for the Case Management and Care Coordination of maternity benefits and services (i.e., Continuity of Care, transfers, and payment), as stipulated in *Section 4* and *Section 5* of this contract.

4.2.19.4 Require care coordination through the gestational period according to the Member's needs.

4.2.19.5 Newborn Hearing Screenings

Newborn Hearing Screenings are included in the Core Benefits when they are rendered to Newborns in an inpatient hospital setting. This Procedure is not included in the DRG; therefore, the Contractor shall work with Providers to ensure payment. The Contractor shall be held financially responsible for payment of this Screening.

4.2.20 Outpatient Services

Outpatient services are defined as those preventive, diagnostic, therapeutic, rehabilitative, surgical, mental health, facility services for dental and Emergency Services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding twenty- four (24) hours. Outpatient or ambulatory care facilities include: (a) Hospital Outpatient Departments, (b) Diagnostic/Treatment Centers, (c) Ambulatory Surgical Centers, (d) Emergency Rooms (ERs), (e) End Stage Renal Disease

(ESRD) Clinics and (f) Pediatric HIV Clinics (g) Intensive Outpatient Programs (IOP)/ Partial Hospitalization Program (PHP).

The CONTRACTOR shall:

4.2.20.1 Refer to all applicable Department manuals (e.g. Outpatient Services Provider Manual, Clinical Services Provider Manual, etc.) for additional details regarding this Benefit/service coverage requirement.

4.2.21 Physician Services

Physician services include the full range of physical and Behavioral Health Services.

The CONTRACTOR shall:

4.2.21.1 Ensure all Physician services are medically necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care, and treatment of the specific condition.

4.2.21.2 Not be bound by the current variety of service settings— those being Physician's offices, patients' homes, clinics, and skilled nursing facilities.

4.2.22 Pharmacy / Prescription Drugs

Prescription drug coverage shall be provided by the CONTRACTOR according to the Member's needs. The pharmacy benefit provided by the CONTRACTOR must comply with the coverage and benefit guidelines set forth in Section 1927(k)(2) of the Social Security Act and 42 CFR § 438.3(s)(1). Under the pharmacy benefit, the CONTRACTOR must adhere to a single Preferred Drug List (PDL) as set forth by the DEPARTMENT.

4.2.22.1 The Department shall, at its discretion, exclude specific medications or classes of medications from the CONTRACTOR's responsibility.

4.2.22.2 Single Preferred Drug List (sPDL)

Must implement a single Preferred Drug List (sPDL) to encourage the use of the most cost-effective medication within a drug class.

4.2.22.2.1 Negative PDL changes must be published on the CONTRACTOR's website and communicated to the Department at least thirty (30) days prior to implementation. This thirty (30) day requirement applies to both the website posting and communication to the Department.

4.2.22.2.2 The CONTRACTOR shall follow all requirements set out in the FMT file used to disseminate the Department's single PDL.

4.2.22.2.3 All rebatable Food and Drug Administration (FDA)-approved medications must ultimately be covered by the CONTRACTOR.

4.2.22.2.4 The CONTRACTOR shall not retain supplemental rebates for any products billed through the Pharmacy Benefit.

4.2.22.2.5 The Department may elect to restrict the CONTRACTOR's ability to make PDL changes.

4.2.22.3 Authorization Requirements

The CONTRACTOR shall:

4.2.22.3.1 Have the ability to require Prior Authorization or Clinical Edits on non-preferred medications to ensure appropriate use and to encourage the use of preferred medications.

4.2.22.3.2 Provide a response to requests for Pharmacy Prior Authorization within twenty-four (24) hours of the request in accordance with all requirements set forth in 42 CFR 438.210(d).

4.2.22.3.3 Authorize the pharmacy Provider to issue a seventy-two (72) hour supply to the Members in emergent situations for drugs subject to a Prior Authorization until such time as a Prior Authorization decision is received per Section 1927(d)(5) of the Act, 42 U.S.C § 1396r 8(d)(5)(B) and 42 CFR § 438.3(s)(6);

4.2.22.3.4 Not require the Member's involvement or participation in the resolution of a prescription issue related to the issuance of a Prior Authorization.

4.2.22.3.5 Allow an override/early refill when a Member is admitted to either a Long-Term Care (LTC) and/or Psychiatric Residential Treatment Facility (PRTF) to ensure Continuity of Care regarding prescription medications.

4.2.22.4 Emergency Supply

The CONTRACTOR shall have a written process that addresses a pharmacy benefit seventy-two (72)-hour emergency supply of medication, including drugs requiring prior approval and in accordance with Sec. 1927. [42 U.S.C. § 1396r–8](d)(5)(B) of the Act. The seventy-two (72)-hour emergency procedure should not be used for routine and continuous overrides and may be subject to audit.

4.2.22.4.1 At a minimum, the CONTRACTOR must allow one emergency supply fill/dispensing per medication per one-hundred and eighty (180) days.

4.2.22.4.2 A seventy-two (72)-hour emergency supply may require utilizing an unbreakable package quantity to include medications such as, but is not limited to, metered dose inhalers, nasal sprays, topical preparations, and powders for reconstitution which can be dispensed as a 72-hour supply.

4.2.22.4.3 The Contractor shall reimburse the dispensing pharmacy for the ingredient cost and the dispensing fee for both the seventy-two (72)-hour emergency supply and the balance of the prescription filled.

4.2.22.5 Non-Managed Products

Disseminate information regarding coverage allowance for non-managed products to Members in the CONTRACTOR's Medicaid Managed Care Member's handbook and to Providers in the CONTRACTOR's Provider manual.

4.2.22.6 Medications Dispensed by a Specialty Pharmacy

Provide a mechanism to allow the initial supply to be provided via a local pharmacy from which the medication is available if the CONTRACTOR requires that certain medications be obtained from a specialty pharmacy and/or the Member's medical circumstances require more immediate access than is available from the specialty pharmacy.

4.2.22.7 High Cost No Experience Pharmaceuticals

The Department shall operate a pharmacy risk mitigation program to limit the Contractor's exposure to high-cost pharmacotherapies without utilization experience. The Department shall select medications for inclusion in this program based on anticipated cost of therapy and FDA approval date. Medications will generally be removed from the program once the approval date is on or before the beginning of the rate setting experience period. The Department shall determine which medications are included in the pharmacy risk mitigation program.

The CONTRACTOR shall not be held at risk but will be responsible for provider reimbursement of high cost no experience pharmaceuticals as outlined annually in the Department's rate certification. Payments for these medications must comply with 42 CFR § 447.362. Reimbursement from the Department shall be limited to the lesser of the total cost of the pharmaceutical therapy paid by the Contractor or the reimbursement rate fee for service (FFS) coverage. All claims requested for reimbursement are subject to Departmental review and approval.

4.2.22.7.1 Comply with the reporting requirements for high cost no experience pharmaceuticals as outlined in the Managed Care Report Companion Guide.

4.2.22.8 Department-Manufacturer Pharmacy Rebate Disputes

Assist the Department in dispute resolution by providing information regarding Claims and Provider details if there is a dispute between the Department and the drug manufacturer regarding federal drug rebates. Failure to collect drug rebates due to the CONTRACTOR's failure to assist the Department will result in the Department's recouping from the CONTRACTOR any determined uncollected rebates.

4.2.22.9 Medications Procured Through the 340B Program

The Contractor shall indicate, in a manner prescribed by the Department, which pharmacy Encounters were procured through the 340B Program.

4.2.22.9.1 When processing medications through point-of-sale pharmacy benefit that were purchased through the 340B Program, covered entities must submit a value of "20" in the Submission Clarification Code field.

4.2.22.10 Drug Utilization Review

The Contractor shall:

4.2.22.10.1 Be in compliance with section 1004 of the SUPPORT Act pursuant to 42 CFR § 438.3(s), maintaining DUR program(s) that comply with requirements in section 1927(g) of the Act and 42 CFR part 456, subpart K.

4.2.22.10.2 Have in place claims review limitations as described in Section 1902(oo)(1)(A)(i)(I)&(II) of the SSA and a claims review automated process as described in Section 1902(oo)(1)(A)(i)(III) of the SSA. Pursuant to Section 1932(i) of the SSA, the Contractor must be in compliance with the applicable provisions of 42 CFR § 438.3(s)(2), 42 CFR § 438.3(s)(4), and 42 CFR § 438.3(s)(5).

4.2.22.10.3 Perform, in a manner consistent with industry standards, prospective drug utilization review for all pharmacy Claims.

4.2.22.10.4 Participate, in a manner prescribed by the Department, in a process for retrospectively reviewing drug utilization in the Medicaid Program that identifies potential fraud or abuse of controlled substances by enrolled individuals, health care providers and pharmacies and for educating Providers about inappropriate or inefficient prescribing.

4.2.22.10.5 Participate in the Department's Drug Utilization Review (DUR) Board, as described by the Department.

4.2.22.10.6 Provide the information necessary for the Department and its Contractors to complete the annual DUR report required pursuant to 42 CFR § 456.712.

4.2.22.11 Reporting of Pharmacy Claim Level Reimbursement

To facilitate accurate measurement of the pharmacy component of the Medical Loss Ratio (MLR) the CONTRACTOR shall provide Claim-level pharmacy reimbursement detail, reflecting the amount paid by the Pharmacy Benefit Manager (PBM) to the pharmacy Provider, per *Section 7* of this contract.

4.2.22.12 Refills When the Governor of South Carolina issues a "State of Emergency"

When the Governor of South Carolina issues a "State of Emergency," the Plan shall administer pharmacy benefits in accordance with S.C. State of Emergency Law (Section 40- 43-170).

4.2.22.13 Member Steerage

The CONTRACTOR shall ensure that any Pharmacy Benefit Manager (PBM) that is utilized to provide Pharmacy Services to its Members must adhere to any requirements as set forth in Article 21, Chapter 71, Title 38 of the S.C. Code – Pharmacy Benefits Managers Section 38-71-2230 (G).

4.2.22.14 Single PDL Compliance

During the initial phase of the implementation of the single PDL (July1, 2024-December 31, 2024) the Department will work with the CONTRACTOR to collaboratively share information regarding the CONTRACTOR'S compliance with and adherence to the Department's PDL.

After the initial implementation phase (starting January 1, 2025) the Department will begin monitoring the CONTRACTOR for compliance with and adherence to the Department's PDL.

On a quarterly basis, the CONTRACTOR shall achieve a PDL compliance rate of 95%.

The PDL compliance rate shall be measured as:

$$PDL\ COMPLIANCE = \frac{Total\ Pharmacy\ Claims\ minus\ NPD\ Claims}{Total\ Pharmacy\ Claims}$$

Where "Total Pharmacy Claims" is defined as the total number of pharmacy claims with a date of service during the applicable quarter.

Where "NPD Claims" is defined as the number of pharmacy claims during the quarter for which the National Drug Code (NDC) is indicated as Non-Preferred (NPD) on the Formulary Management Tool (FMT) file as of the date of service of the claim.

4.2.22.14.1 CONTRACTOR will conduct a review and submit a report in a format developed by the DEPARTMENT on a quarterly basis using the PDL compliance rate formula. For any period in which the CONTRACTOR fails to achieve a compliance rate of 95%, the CONTRACTOR shall also include:

4.2.22.14.1.1 An additional analysis, at the PDL class level, indicating which PDL classes contributed to the failure to achieve the PDL compliance rate.

4.2.22.14.1.2 The criteria used to approve non-Preferred drugs in each of the classes that contributed to the failure to achieve the PDL compliance rate.

4.2.22.14.1.3 An attestation that the PDL was administered according to the Department's guidelines, or, if the CONTRACTOR failed to do so, a description of how the CONTRATOR deviated from the Department's guidelines.

4.2.22.14.1.4 A description of any market factors, such as drug shortages or modifications to treatment guidelines, that contributed to the CONTRACTOR's failure to achieve the PDL compliance rate.

4.2.22.14.2 Upon review of the CONTRACTOR's analysis for failure to achieve the PDL compliance target and after consideration of any mitigating factors included in analysis, the Department may implement a Corrective Action Plan (CAP) for failure to meet the PDL compliance rate.

4.2.22.14.3 The Department will continue to evaluate and refine the monitoring for adherence and compliance to its PDL and reserves the right to update requirements to this adherence program with appropriate notice to the CONTRACTOR.

4.2.22.15 Additional Covered Outpatient Drug Requirements

4.2.22.15.1 The Contractor, in compliance with Section 1902(a)(85) of the Act and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, shall:

4.2.22.15.1.1 Complete a review of antipsychotic agents for appropriateness for all children eighteen (18) and under including foster children based on approved indications and clinical guidelines;

4.2.22.15.1.2 Implement prospective safety edits on subsequent fills of opioid prescriptions, as specified by the state, which may include edits to address days' supply, early refills, duplicate fills and quantity limitations for clinical appropriateness;

4.2.22.15.1.3 Implement prospective safety edits on maximum daily morphine milligram equivalents (MME) on opioids prescriptions to limit the daily morphine milligram equivalent;

4.2.22.15.1.4 Implement retrospective reviews on opioid prescriptions exceeding above limitations on an ongoing basis;

4.2.22.15.1.5 Implement retrospective reviews on concurrent utilization of opioids and benzodiazepines as well as opioids and antipsychotics on an ongoing basis.

4.2.22.15.2 In accordance with CMS Final Rule CMS-2434-F and CFR 438.3(s), the Contractor shall:

4.2.22.15.2.1 Assign and exclusively use unique Medicaid-specific Bank Identification Number (BIN) and Processor Control Number

(PCN) combination, and group number identifiers for all Member identification cards for pharmacy benefits.

4.2.22.15.2.2 Require any Subcontractor the Contractor contracts with for the delivery or administration of the covered outpatient drug benefit, to report separately to the Contractor the amounts related to: (1) the incurred claims described in § 438.8(e)(2) such as reimbursement for the covered outpatient drug, payments for other patient services, and the fees paid to providers or pharmacies for dispensing or administering a covered outpatient drug; and (2) administrative costs, fees and expenses of the Subcontractor.

4.2.22.16 The Contractor shall not require the Member to utilize mail-order fulfillment of prescription drugs in order to accommodate Member choice.

4.2.23 Rehabilitative Therapies for Children—Non-Hospital Based

The Title XIX SC State Medicaid Plan provides for a wide range of therapeutic services available to individuals under twenty-one (21) years of age who have sensory impairments, intellectual disabilities, physical disabilities, and/or developmental disabilities or delays. These services are provided through the Local Education Authorities (LEA) or the Private Rehabilitation Services programs.

The CONTRACTOR shall:

4.2.23.1 Be responsible for private and/or state-based Providers.

4.2.23.2 Refer to Departmental manuals for specific coverage requirements.

4.2.24 Sterilization

The CONTRACTOR shall:

4.2.24.1 Provide sterilization services in accordance with 42 CFR Part 441 Subpart F.

4.2.24.2 Ensure sterilization for a male or female meet the reporting and documentation requirements as outlined in this contract and applicable Provider manuals.

4.2.24.2.1 The Contractor shall maintain original versions of required forms in the Member's Health Record and a copy must be submitted to the Contractor for retention in the event of audit.

4.2.24.2.2 In the event the requesting Physician does not complete and submit the required forms, it is permissible for the Contractor to delay or deny payment until proper completion and submission of the required form(s).

4.2.25 Substance Abuse

The contractor shall use recognized SAMHSA and NIDA guidance to provide substance abuse services including alcohol and other drug abuse treatment services provided by private Opioid

Treatment Providers, the Department of Alcohol and Other Drug Abuse Services (DAODAS), and other licensed and qualified South Carolina Medicaid Network Providers.

The CONTRACTOR shall:

4.2.25.1 Provide alcohol and other drug abuse services that are medically necessary and appropriate for the Member's needs.

4.2.25.2 Not require Prior Authorization of any opioid treatment program clinic services described in the Medicaid Clinic Services manual.

4.2.25.3 Be responsible for all medically necessary services provided by DAODAS and other licensed and qualified South Carolina Medicaid Network Providers.

4.2.25.4 Comply with the guidelines as outlined in applicable Provider manuals.

4.2.25.5 Medication Assisted Therapy (MAT) Minimum Coverage Criteria

4.2.25.5.1 The Contractor shall provide all eligible Members who meet the Medical Necessity criteria for the receipt of MAT Services to assist in the treatment of Opioid Use Disorder (OUD).

4.2.25.5.2 The use of less restrictive parameters and the approval of therapy for a period longer than what is allowed by the Department are permissible.

4.2.25.5.3 The Contractor retains the flexibility to require that specific medications be delivered through a particular benefit (e.g., medical or pharmacy) or to require the use of a particular specialty pharmacy through the administration of MAT Services.

4.2.25.5.4 For additional guidelines related to providing MAT Services, the Contractor shall refer to applicable Provider manuals and supportive documents.

4.2.26 Transplant and Transplant-Related Services

Medically necessary and non-investigational/experimental organ and tissue transplants.

The CONTRACTOR shall:

4.2.26.1 Be responsible for transplant services and associated costs as outlined within Sections 1903(i) final sentence, and 1903(i)(1) of the Social Security Act.

4.2.26.2 Reimburse for all transplant and transplant related services including the transplant event.

4.2.27 Vaccine Services

The CONTRACTOR shall be responsible for all Medicaid covered vaccination services.

4.2.28 Vision Care Services

All vision services for Members are described in the Department's Physicians, Laboratories, and Other Medical Professionals Provider Manual.

The CONTRACTOR shall:

4.2.28.1 Be responsible for all vision services for Members under twenty-one (21) years of age and limited Benefits for adults over twenty-one (21) years of age.

4.2.28.2 Be responsible for the same level of vision Benefits and services covered under the Medicaid FFS Program and refer to the Department's applicable Provider manuals regarding Benefits.

4.2.28.3 Have the discretion to use an approach to coverage that differs from the Medicaid FFS Program.

4.3 Additional Services

4.3.1 General Provisions

4.3.1.1 The CONTRACTOR may only offer Additional Services as approved by the Department to all enrolled Members.

4.3.1.2 These Additional Services are health care services that are not covered by the South Carolina State Plan for Medical Assistance and/or are in excess of the amount, duration, and scope of those listed in this contract.

4.3.1.3 The Department shall not provide any reimbursement for these Additional Services.

4.3.1.4 Ensure transportation for these Additional Services is the responsibility of the Medicaid Managed Care Member and/or CONTRACTOR.

4.3.1.5 The CONTRACTOR shall inform all Members about its Additional Services through proactive engagement and outreach to be administered on a biannual basis.

4.3.1.5.1 Anticipated engagement and outreach activities for Additional Services shall be outlined in the annually submitted Marketing Plan as defined in *Section 12* of this contract.

4.3.1.6 Additional Servies shall be implemented for the duration of the Contract period, or a minimum of three (3) years, unless a written exception is granted by the Department.

4.3.1.7 The Contractor shall administer Additional Services in accordance with any applicable service standards pursuant to this Contract, applicable waivers, and any applicable SCDHHS Provider Manuals.

4.3.2 Types of Additional Services

The Contractor may offer the following Additional Services:

4.3.2.1 Services in excess of the amount, duration, and scope of those listed in this Contract for its respective Members.

4.3.2.2 Other services and benefits not listed in the Additional Services Chart, upon approval of the Agency.

4.3.3 Approval of Additional Services

4.3.3.1 Additional Services shall be submitted in the form and manner prescribed by the Department. Refer to the Managed Care Report Companion Guide for additional information regarding submission details.

4.3.3.2 The Department shall review Additional Service requests in a timely manner. During review, the Department may request additional information or documentation from the Contractor. If changes to submitted Additional Services are required, there will be no more than one resubmission permitted for the same Additional Service.

4.3.4 Modifications to Additional Services

4.3.4.1 The Contractor's Additional Services may only be changed in a manner and format approved by the Department, if determined by the Department to be beneficial to the Members.

4.3.4.2 The Contractor may increase its Additional Services upon approval by the Department.

4.3.4.3 A request for addition, modification, or termination shall be submitted sixty (60) calendar days prior to the intended implementation date of the desired modification.

4.3.4.4 Once a modification has been approved, the CONTRACTOR shall update all marketing materials and publications within thirty (30) calendar days of approval. The Contractor shall follow appropriate Marketing Review processes prior to use, in accordance with *Section 12* of this contract.

4.3.5 Reporting of Additional Services

4.3.5.1 The Contractor shall submit the Additional Services Impact Report annually, at a date set by the Department. Refer to the Managed Care Report Companion Guide for additional reporting requirements.

4.3.6 In Lieu of Services (ILOS)

The CONTRACTOR may cover cost effective alternative services or settings as an In-Lieu of Service (ILOS), in accordance with 42 CFR § 438.3(e) (2), when the following criteria are met:

4.3.6.1 The Department determines that the alternative service or setting is medically appropriate, approvable as an authorized State Plan service, and is a cost-effective substitute for the covered service or setting under the State Plan.

4.3.6.2 ILOS can be immediate or long-term substitutions when expected to reduce or prevent future need for such State Plan service or setting. (42 CFR §§ 438.2 and 457.10)

4.3.6.3 The Member is not required by the CONTRACTOR to use the alternative service or setting. (42 CFR §§ 438.3(e)(2) and 457.1201(e))

4.3.6.4 The CONTRACTOR shall seek prior approval from the Department prior to offering such ILOS and comply with any Policies and Procedures established by the Department including:

4.3.6.4.1 Submission for approval should include research demonstrating the ILOS as medically appropriate, clearly defining the service provider, targeted population, and criteria for the ILOS.

4.3.6.4.2 Submission for approval demonstrates cost-effective analysis, including comparison of the proposed services to the intended service(s). Submission includes suggested claims/encounter coding. [42 CFR § 438.16(d)(1)(vi)]

4.3.6.5 The CONTRACTOR shall ensure that members receiving foster care through the Department of Social Services receive care in accordance with the Foster Care Policies listed in this contract.

4.4 Excluded Services

Excluded Services shall be defined as those services that Members may obtain under the South Carolina State Plan but for which the CONTRACTOR is not financially responsible. Excluded services shall include Medical (Non-Ambulance) Transportation, Dental Services, Targeted Case Management, and those services offered through the Department's waiver programs.

4.4.1 The CONTRACTOR shall be responsible for informing and educating members on how to access Excluded Services, providing all required referrals, and assisting in the coordination of scheduling such services.

4.4.2 Non-Emergency Medical Transportation (NEMT) Requirements

Non-Emergency Medical Transportation (NEMT) is defined as transportation of the Member to and/or from a Medicaid Covered Service to receive Medically Necessary care. This transportation is only available to Eligible Beneficiaries who cannot obtain transportation on their own through other available means, such as family, friends, or community resources.

4.4.2.1 The Contractor shall assist the Member in obtaining medical transportation services through the Department's transportation broker system as part of its Care Coordination responsibilities.

4.4.3 Dental Services

Routine and emergency dental services are available to those Members under the age of twenty-one (21). Limited dental services are available to those Members aged twenty-one (21) and over. The dental Program for all Members is administered by the Department's dental broker and is not included as a Managed Care Core Benefit.

4.4.3.1 The Dental Broker maintains responsibility for the determination of Medical Necessity for the use of facilities used for dental services provided in ambulatory surgical centers and operating rooms. The Contractor shall comply with the determination and pay

facility fees for approved services. The facility is responsible for providing the authorization for care in the facility to the Contractor.

4.4.4 Targeted Case Management (TCM) Services

Services that assist individuals with specialized needs Eligible under the State Plan in gaining access to needed medical, social, educational, and other services to include a systematic referral process to the service with documented follow-up.

TCM services are available to alcohol and substance abuse individuals, children in foster care mentally ill adults, emotionally disturbed children, children in the juvenile justice system, sensory impaired individuals, individuals with intellectual disabilities or a related disability, individuals with head or spinal cord injury or a related disability, children and adults with sickle cell disease and adults in need of protective services. Patients who are dually diagnosed with complex social and medical problems may require TCM services from more than one Case Management Provider. The Department is financially responsible for TCM programs.

The CONTRACTOR shall:

4.4.4.1 Be responsible for developing a program for coordinating health care for Members that require TCM services that avoids duplication and ensures that the Member's needs are adequately met. This requires that the CONTRACTOR and the Targeted Case Management agency develop a system for exchanging information—that is, a systematic referral process to Providers for medical education, legal and rehabilitation services with documented follow up to ensure that the necessary services are available and accessible for each Eligible Member.

4.5 Medical Necessity Determination

The CONTRACTOR shall define Medical Necessity in accordance with 42 CFR § 438.210(a)(5). Medically Necessary Services are those services utilized in the State Medicaid Program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State Policy and Procedures.

The CONTRACTOR shall:

4.5.1 Be required to provide medically necessary and evidence-based appropriate care to Members in the provision of Core Benefits and services outlined in this contract.

4.5.2 Furnish Core Benefits and services in accordance with Medical Necessity and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries up to the limits as specified in the Medicaid FFS Program as defined in the State Plan, administrative rule and applicable Provider manuals.

4.5.3 Establish Procedures for the determination of Medical Necessity. The determination of Medical Necessity shall be made on a case-by-case basis and in accordance with the definition of Medical Necessity defined by the Department and regulations. This requirement should not be construed as to limit the CONTRACTOR's ability to use medically appropriate cost- effective alternative services.

4.5.4 Defer to the Department to make final interpretation of any disputes about Medical Necessity and continuation of Core Benefits covered under this contract. The decision by the Department shall be considered final and binding upon the CONTRACTOR.

4.5.5 Be responsible for provision of the service, unless otherwise exempted by the Department, if the amount, duration and/or scope of service is modified under the Medicaid FFS Program.

4.5.6 Honor and pay for Core Benefits and services for new Members or when a new Benefit is added as a Core Benefit in accordance with this contract.

4.5.7 Medically Necessary Services shall include those medical services which:

4.5.7.1 Are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Member;

4.5.7.2 Are provided at an appropriate facility and at the appropriate level of care for the treatment of a Member's medical condition;

And

4.5.7.3 Are provided in accordance with generally accepted standards of medical practice.

4.5.8 For the provision of Medically Necessary Services, the Contractor shall be responsible for covering services that:

4.5.8.1 Address the prevention, diagnosis, and treatment of a Member's disease, condition, and/or disorder that results in health impairments and/or disability.

4.5.8.2 Are related to the ability for a Member to achieve age-appropriate growth and development.

4.5.8.3 Are related to the ability for a Member to attain, maintain, or regain functional capacity.

4.6 Out-of-Network Coverage

The CONTRACTOR shall

4.6.1 Provide or arrange for out-of-network coverage of Core Benefits in emergency situations and Non-Emergency situations—when service cannot be provided by an in-network Provider in the required timeframe and in accordance with *Section 8* of this contract.

4.7 Second Opinions

The CONTRACTOR shall:

4.7.1 Provide for a second opinion in any situation where there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by a Member, parent and/or legally appointed Representative.

4.7.2 Require contracted Providers to provide the second opinion or the CONTRACTOR shall arrange for a Member to obtain one from an out-of- network Provider when a qualified Provider is not available in network.

4.7.3 The second opinion shall be provided at no cost to the Member.

4.8 Moral and Religious Objection

In Network Providers cannot be required to reimburse for or provide coverage of a counseling or referral service if the Provider objects to the service on moral or religious grounds.

If the Contractor and/or the CONTRACTOR's In Network Providers elect not to provide coverage of a service covered under this contract because of an objection on moral or religious grounds, the CONTRACTOR shall, in accordance with Section 1932(b)(3)(B)(i) of the Act, 42 CFR § 438.10(g)(2)(ii)(A) - (B), 42 CFR § 438.102(b)(1)(i)(A)(2), and 42 CFR § 438.102(b)(2):

4.8.1 Establish a method for identifying such Providers;

4.8.2 Notify the Department of the Providers that will not provide the service whenever it adopts such a policy;

4.8.3 Notify the Department of any service the Contractor elects not to provide because of an objection on moral or religious grounds during the Application Certification Process or prior to signature of any contract renewals;

4.8.4 Furnish information to the Member on how to receive the service if the Contractor and/or the CONTRACTOR's In Network Providers elect not to provide coverage of a service covered under the contract because of an objection on moral or religious grounds.

4.8.5 Provide notice to potential Members before and during Enrollment.

4.8.6 Maintain a list of Providers who do not participate in family planning and make that list available to the Department;

4.8.7 Have a process of informing current Members of Providers who do not provide certain services;

4.8.8 Ensure that any services the Contractor wishes to discontinue coverage of based on moral or religious objections must inform Members at least 30 days prior to the effective date of the policy for any particular service;

4.8.9 Update the Provider directory monthly to identify Providers that do not provide a Covered Service due to moral or religious grounds.

Section 5. CARE COORDINATION AND CASE MANAGEMENT

5.1 General Care Coordination and Case Management Requirements

As part of the Care Coordination and Case Management System, the CONTRACTOR shall be responsible for the management, coordination, and Continuity of Care for all its Members and shall develop and maintain Policies and Procedures to address this responsibility. The CONTRACTOR's Care Coordination activities and Case Management Program shall be based on sound evidence and conform to the requirements and industry standards stipulated in the NCQA requirements for Complex Case Management and by the *Standards of Practice of Case Management* released by the Case Management Society of America (CMSA).

The CONTRACTOR shall:

5.1.1 Make a best effort to conduct an initial screen of each Member's needs, within ninety (90) days of the effective date of Enrollment for all new Members, including subsequent attempts if the initial attempt to contact the Member is unsuccessful. (42 CFR § 438.208(b)(3))

5.1.2 Utilize appropriate assessment tools and Health Care Professionals in assessing a Member's physical and Behavioral Health care needs.

5.1.2.1 Inform other Managed Care Organizations the results of a Member's assessments should a Member transition to a different Medicaid Managed Care program, to prevent duplication of those activities and to ensure transition of care requirements in accordance with 42 CFR § 438.208(b)(4).

5.1.3 Develop Programmatic-Level Policies and Procedures for Care Coordination and Case Management services.

5.1.4 As specified in 42 CFR § 438.208(c), use Care Coordination and Case Management as a continuous process for:

5.1.4.1 The assessment of a Member's physical health, Behavioral Health and social support service and assistance needs.

5.1.4.2 Identification of persons who need LTSS services or persons with special health care needs.

5.1.4.3 The development of a Plan which must be provided annually, for Department approval, to include the Contractor's procedures related to contacting and assessing the needs for LTSS services or other special health care needs.

5.1.4.3.1 Ensure the plan be developed in accordance with any applicable state quality assurance and utilization review standards.

5.1.4.3.2 Ensure the treatment or service plan be reviewed and revised upon reassessment of functional need, at least every twelve (12) months, or when the Member's circumstances or needs change significantly, or at the request of the Member.

5.1.4.4 The identification of physical health services, Behavioral Health Services, LTSS, special needs and other social support services and assistance necessary to meet identified needs.

5.1.4.4.1 The Contractor shall ensure that those Members with Special Health Care Needs who need a course of treatment or regular care monitoring will have direct access to a specialist as appropriate for the Member's condition and identified needs. (See 42 CFR 438.208(c)(4))

5.1.4.5 The assurance of timely access to and provision, coordination and monitoring of the identified services associated with physical health, Behavioral Health, LTSS, special needs, and social support services and assistance to help the member maintain or improve his or her health status including coordinating access to services not covered by the plan.

5.1.5 Provide the Member with information on how to contact their designated Case Manager or entity. (See 42 CFR § 438.208(b)(1))

5.2 Member Risk Stratification Requirements

The CONTRACTOR shall stratify its Members based on risk.

5.2.1 Member Risk Stratification Methodology

The CONTRACTOR may utilize its own methodologies (e.g., information systems/software packages) for Member risk stratification.

5.2.2 Member Risk Stratification Categories

The CONTRACTOR shall classify each Member in one of the four risk categories: (1) Low-Risk, (2) Moderate-Risk or (3) High-Risk (4) Intensive Case management.

5.2.3 Member Risk Stratification for Special Populations

The Department may require specific risk assessment tools for special population groups and Members with special health care needs as stipulated in *Section 4* of this contract.

5.2.4 Ensure that those Members identified as having a Serious Mental Illness (SMI) or those Members under the age of 18 within the Foster Care System receive Care Coordination and Case Management Services as it is defined in this Section.

5.3 Member Risk and Care Coordination and Case Management Activity Requirements

The CONTRACTOR shall provide Care Coordination and Case Management activities based on the Member's risk stratification.

5.3.1 General Care Coordination and Case Management Activities for All Members

The CONTRACTOR shall:

5.3.1.1 Incorporate wellness promotion and illness prevention activities within its Care Coordination and Case Management Programs.

5.3.1.2 Consider any referral from a Provider or the Department when determining the appropriate level of Case Management.

5.3.1.3 Consider concurrent mental illness and substance abuse disorders when evaluating the appropriate level of intervention.

5.3.1.4 Consider essential elements of Case Management-related activities proposed and adopted by CMS for Members of all ages who have functional limitations and/or chronic illnesses.

5.3.1.5 Provide adequate care planning and transition strategies for a comprehensive person-centered program.

5.3.1.6 Monitor all Member discharge plans from behavioral health inpatient admissions to ensure that they incorporate the Member's needs for continuity in existing behavioral health therapeutic relationships.

5.3.1.7 Ensure the Member's family members, guardians, outpatient individual practitioners and other identified supports are given the opportunity to participate in Member treatment to the maximum extent practicable and appropriate, including behavioral health treatment team meetings and discharge plan development. For adult Members, family members and other identified supports may be involved in the development of the discharge plan only if the member consents to their involvement.

5.3.1.8 Designate care coordination and case management staff who are responsible for identifying and providing care coordination and case management to Members who remain in the hospital for non-clinical reasons (i.e. absence of appropriate treatment setting availability, high demand for appropriate treatment setting, high-risk members and members with multiple agency involvement).

5.3.1.9 Ensure the care coordinator/ case manager shall assume a lead role in identifying a service provider that can meet the Member's needs even when there are multiple state agencies involved in a child's care. If placement is needed, the care coordinator/ case manager shall coordinate, maintain routine contact with other state agencies involved in the member's care, and document in the Member's record all efforts to find an appropriate placement.

5.3.2 Low-Risk Member Care Coordination and Case Management Activity Requirements

The CONTRACTOR shall:

5.3.2.1 Provide Members at Low-Risk with prevention and wellness messaging and condition-specific materials.

5.3.3 Moderate-Risk Member Care Coordination and Case Management Activity Requirements

The CONTRACTOR shall:

5.3.3.1 Provide Members at Moderate-Risk with interventions targeted at the Member's specific problems and aimed at improving overall health and preventing any further illness/disease progression or increase in risk.

5.3.4 High-Risk Member Care Coordination and Case Management Activity Requirements

The CONTRACTOR shall:

5.3.4.1 Provide Members at High-Risk with Enhanced Care Coordination and Case Management to include regular telephonic contact.

5.3.4.2 Ensure those Members who are receiving services out of state are assigned to the High-Risk Member Case Management Stratification Level.

5.3.5 Intensive Case Management (ICM)

5.3.5.1 Intensive Case Management Eligibility Requirements

5.3.5.1.1 The Department requires that the CONTRACTOR address Intensive Case Management for the following:

5.3.5.1.1.1 Members identified with a Serious Mental Illness and who have experienced any one of the following within the most recent twelve (12) months:

5.3.5.1.1.1.1 Two (2) or more inpatient or emergency department visits for a behavioral or mental health need.

5.3.5.1.1.1.2 Admission to inpatient psychiatric care.

5.3.5.1.1.1.3 An existing referral for Interagency Escalation as defined by the department.

5.3.5.1.1.1.4 Admission to a Psychiatric Residential Treatment Facility (PRTF).

5.3.5.1.1.1.5 Applying to or residing in a Community Residential Care Facility (CRCF).

5.3.5.1.1.1.6 The Member has been identified as having one (1) or more suicide attempts.

5.3.5.1.1.2 Members under the age of 18 who are placed in foster care and who have four (4) or more co-occurring conditions.

5.3.5.1.1.3 Members identified by the Department under the age of 18 who are involved with the Department of Juvenile Justice (DJJ) and engaged with the Department of Mental Health (DMH).

5.3.5.1.1.4 Members identified by the Department as subject to the Consolidated Appropriations Act.

5.3.5.1.1.5 Adult Members identified by the Department as an SMI At-Risk Population.

5.3.5.1.2 The Department reserves the right to make adjustments to the list of criteria of those individuals identified as being eligible for ICM.

5.3.5.2 Intensive Case Management Activity Requirements

5.3.5.2.1 The CONTRACTOR shall, within thirty (30) days of assignment:

5.3.5.2.1.1 Ensure Informed Choice for Members utilizing the Department's template.

5.3.5.2.1.2 Ensure Members are assessed for medical and behavioral health needs.

5.3.5.2.1.3 Develop a Person-Centered Care Plan for each member. This plan must:

5.3.5.2.1.3.1 Identify the individual's strengths, preferences, needs, and desired outcomes.

5.3.5.2.1.3.2 Identify specific supports and services that build on the individual's strengths and preferences to meet the individual's needs and achieve desired outcomes regardless of whether those services and supports are currently available.

5.3.5.2.1.3.3 Include a list of specific Providers that can provide the identified supports and services.

5.3.5.2.1.3.4 Include a transition planning section for those members in need of transitioning from an institutional setting to a community setting.

5.3.5.2.1.4 Conduct telephonic or virtual check-ins with member and/or member caregiver(s) and guardian(s) every thirty (30) days.

5.3.5.2.1.5 Review the plan of care in the members residence or the least restrictive community setting for the member every ninety (90) days.

5.3.5.2.1.6 Serve as a liaison to and coordinate with relevant providers, natural supports, and peer support specialists as needed.

5.3.5.2.1.7 Proactively assist individuals directly with gaining access to Home and Community-Based Services and physical health services, transportation, and community connections as identified in the Person-Centered Care Plan.

5.3.5.2.1.8 Review and renew the member's informed choice, assessments, and the Person-Centered Plan of Care annually and/or within seven (7) calendar days of a Significant Change.

5.3.5.2.1.9 Ensure an adequate number of trained Case Managers to fulfill obligations under this Contract.

5.3.5.2.1.10 The Department may require specific evidence- based risk assessment and care planning tools for special population groups as stipulated in this Section of the contract or in the Managed Care Process and Procedure Manual.

5.3.5.3 Intensive Case Management Staffing Requirements

The CONTRACTOR Shall:

5.3.5.3.1 Ensure each member of this population is assigned a designated Case Manager.

5.3.5.3.2 Ensure the Case Manager caseload ratio does not exceed 1:60 for Members in this program.

5.3.5.3.3 Ensure Case Managers possess specialized knowledge, training, and cultural competency to provide services to populations designated in this Section of the contract.

5.3.5.3.4 Ensure Case Managers have completed the Department's approved Person-Centered Care Planning training.

5.3.5.3.5 Ensure any persons providing Case Management services to those Members receiving ICM must meet the following minimum qualifications:

5.3.5.3.5.1 Master's degree in social work, nursing, rehabilitation, psychology or related health and human services area, and who have documented experience with the assigned Member population.

Or

5.3.5.3.5.2 Bachelor's Degree from an accredited university or college in nursing, psychology, social work, early childhood education, child development or a related field or Bachelor's degree in another field and has a minimum of 45 documented training hours related to behavioral health issues and treatment.

5.3.6 Monthly Care Coordination and Case Management Reporting Requirements

The CONTRACTOR shall:

5.3.6.1 Submit a monthly report of all Members that are receiving Care Coordination and Case Management services to include those Members identified as a mandatory service population who the CONTRACTOR has been unable to provide Case Management Services to. Refer to the Managed Care Report Companion guide for additional guidance.

5.4 Care Coordination and Case Management Program Description

The CONTRACTOR shall submit a Case Management and Care Coordination Program Description to the Agency by June 1 of each Contract year. The Case Management and Care Coordination Program Description shall address:

5.4.1 A description of the CONTRACTOR'S procedures for assigning a case manager to enrollees including how the CONTRACTOR shall identify those Members eligible for Intensive Case Management (ICM).

5.4.2 A description of the CONTRACTOR's procedures for documenting a Member's or the Member's authorized representative's rejection of Case Management services.

5.4.3 The responsibilities of the case manager, including participation in all scheduled and any ad hoc meeting(s) for assigned Members (i.e. Interagency Staffing or PRTF Treatment Team Meetings).

5.4.4 How the CONTRACTOR shall implement and monitor the Care Coordination and Case Management program and standards outlined in this Contract.

5.4.5 A description of the CONTRACTOR'S methodology for assigning and monitoring Case Management caseloads and emergency preparedness plans as well as average case assignments per Case Manager.

5.4.5.1 A description of how members are assigned or transferred from one Member risk stratification level to another stratification level and what that transition entails.

5.4.6 A description of the CONTRACTOR's procedures for resolving conflict or disagreement in the care planning process, including guidelines for all participants.

5.4.7 An evaluation of the CONTRACTOR's Care Coordination and Case Management program from the previous year to include lessons learned, strategies for improvement, performance measures, and member satisfaction.

5.4.8 All required elements of the Care Coordination and Case Management program and responsibilities of the Case Manager/Case Manager Supervisor as outlined in this Contract.

5.5 Continuity of Care Activities

The CONTRACTOR's Case Management Program and Policies must address coordination of services for physical and Behavioral Health Services the Member is receiving from another CONTRACTOR's Health Plan or Provider.

5.5.1 General Continuity of Care Activity Requirements

The CONTRACTOR shall:

5.5.1.1 Ensure Continuity of Care activities are consistent with 42 CFR § 438.208 and should provide processes for effective interactions between Members, in-network, and out-of-network Providers and identification and resolution of problems if those interactions are not effective or do not occur.

5.5.1.2 Meet all requirements for Newborn Prior Authorizations in those cases in which a Non-Participating pediatrician provides services to a Newborn due to institutional and/or business relationships; this can include, but is not limited to, post-delivery treatment prior to discharge by a pediatrician who is under contract with a hospital, and in-office services rendered by Non-Contracted Providers within the first sixty (60) Days following hospital discharge.

5.5.1.2.1 The Contractor shall compensate these Non-Participating Providers, at a minimum, the Medicaid fee-for-service rate until such time the Member can be served by a participating Physician or can be transferred to a Health Plan that contracts with the Provider.

5.5.1.2.2 The Contractor shall complete the appropriate documentation for facilitating the PA process for services rendered in an office setting within sixty (60) Days following a Newborn's hospital discharge.

5.5.1.2.3 The Contractor shall refer to the Managed Care Report Companion Guide for additional reporting requirements.

5.5.2 Service Need Determination

The CONTRACOR shall:

5.5.2.1 Assist the Member in determining the need for services outside the Core Benefits and refer the member to the appropriate Provider.

5.5.3 Service Delivery Coordination

The CONTRACTOR shall:

5.5.3.1 Coordinate services between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays. (42 CFR § 438.208(b)(2)(i))

5.5.3.2 Coordinate services the member receives through the delivery of Core Benefits with services reimbursed via Medicaid Fee for Service by the Department. (42 CFR § 438.208(b)(2)(iii))

5.5.3.3 Coordinate services the member receives with community and social support Providers. (42 CFR § 438.208(b)(2)(iv))

5.5.3.4 In the event of termination of a CONTRACTOR's In Network Provider, the CONTRACTOR will continue to pay the Provider until either the Member has finished

the course of treatment or until the Provider releases the Member to another Provider who is within the CONTRACTOR's Provider network.

5.5.3.5 Coordinate services it furnishes to Members with services the Members receive from other contracted entities. (42 CFR § 438.208(b)(2)(ii))

5.5.4 Service Setting Determination

The CONTRACTOR may request the assistance of the Department for referral to the appropriate service setting.

5.5.5 Referral Outside Core Benefits and Services

The CONTRACTOR shall:

5.5.5.1 Coordinate the referral of Members for Excluded Services that are available under the Medicaid FFS Program from South Carolina Medicaid Network Providers.

5.5.5.2 Ensure these services are consistent with the outline and definition of Covered Services in the State Plan.

5.6 Transition of Care Requirements

5.6.1 Program Policies and Procedures

The CONTRACTOR shall develop and implement Policies and Procedures to address transition of care consistent with federal requirements, the Managed Care Process and Procedure Manual for new Members, Members who transition between CONTRACTOR's, Members who transition from Medicaid FFS, and Members still enrolled upon termination or expiration of the contract. (42 CFR § 438.62(b)(1) - (2))

5.6.2 CONTRACTOR Program Staffing and Training Requirements

The CONTRACTOR shall designate a person with appropriate training and experience to act as the transition coordinator. This staff person shall interact closely with the Department's staff and staff from other CONTRACTORs to ensure a safe and orderly transition.

5.6.3 Member Assistance with Health Record Requests

Upon notification of Enrollment of a new member, the receiving CONTRACTOR's Health Plan shall assist the Member with requesting copies of the Member's Health Records from treating Providers, unless the member has arranged for the transfer. Transfer of records shall not interfere or cause delay in providing services to the Member.

5.6.4 Transition of Health Records

The Contractor shall ensure that each Provider furnishing services to Members maintains and shares, as appropriate, a Member's health record in accordance with professional standards, while protecting the Member's privacy in accordance with the privacy requirements in 45 CFR Parts 160 and 164, Subparts A and E, to the extent applicable. (See 42 CFR 438.208(b)(5)

5.6.5 CONTRACTOR Coordination with Department for Member Transition

When relinquishing Medicaid Managed Care Members, the CONTRACTOR shall cooperate with the Department and new treating Providers regarding the course of ongoing care with a specialist or other Provider. The relinquishing CONTRACTOR is responsible for providing timely notification and needed information to the Department, or its designee, regarding pertinent information related to any special needs of transitioning members, if requested. Such information includes but is not limited to provision of any transitioning Member forms required by the Department, information regarding historical Claims paid, and information regarding currently authorized services.

5.6.6 CONTRACTOR Coordination with Providers for Member Transition

In addition to ensuring appropriate referrals, monitoring, and follow-up to Providers within the network, the CONTRACTOR shall ensure appropriate linkage and interaction with Providers outside the network.

5.6.7 Additional Transition of Care Requirements

5.6.7.1 The CONTRACTOR shall be responsible for the cost of the continuation of services to newly enrolled Medicaid Managed Care Members entering the CONTRACTOR's Health Plan.

The CONTRACTOR shall:

5.6.7.1.1 Continue authorized services without requiring Prior Authorization for up to ninety (90) Days,

5.6.7.1.2 Continue authorized services regardless if the service is provided by an in-network or out of network Provider,

Or,

5.6.7.1.3 Until the CONTRACTOR has performed appropriate clinical review(s) and arranged for the provision of medically necessary services without disruption.

And,

5.6.7.1.4 At its discretion, the CONTRACTOR may require Prior Authorization for continuation of services beyond ninety (90) Days; however, the CONTRACTOR is prohibited from denying authorization solely on the basis that the Provider is out-of-network.

5.6.7.2 Inpatient in Hospital at Time of Enrollment

For a Member who is in an inpatient hospital setting at the time of Enrollment in the CONTRACTOR's Health Plan, the member's facility charges shall be the responsibility of the payor at admission.

5.6.7.3 Pregnant at Time of Enrollment

The CONTRACTOR shall provide transition of care for Members who are pregnant or receiving inpatient care. This requirement applies to the following stages of pregnancy:

5.6.7.3.1 Furnish Core Benefits and services in accordance with Medical Necessity and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries up to the limits as specified in the Medicaid FFS Program as defined in the State Plan, administrative rule and Managed Care Process and Procedure Manual.

5.6.7.3.2 Prenatal Care First & Second Trimester; For Members entering the CONTRACTOR's Health Plan in the first or second trimester of pregnancy who are receiving medically necessary covered prenatal care services the day before Enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services. The CONTRACTOR shall provide these services without any form of prior approval and without regard to whether such services are being provided by a contracted or out-of-network Provider until the CONTRACTOR can reasonably transfer the Member to a network Provider without impeding service delivery that, if not provided, might be harmful to the Member's health.

5.6.7.3.3 Prenatal Care Third Trimester; For Members entering the CONTRACTOR's Health Plan in the third trimester of pregnancy who is receiving medically necessary covered prenatal care services the day before Enrollment, the CONTRACTOR shall be responsible for the costs of continuation of such medically necessary prenatal care services without any form of prior approval and without regard to whether such services are being provided by a contracted or out-of-network Provider.

5.6.7.4 Members Enrolled Upon Termination of Provider Contract

In accordance with 42 CFR §430.10(f)(5), the CONTRACTOR must make a good faith effort to give written notice of termination of a contracted In Network Provider for each Member who received his or her primary care from or was seen on a regular basis by the terminated provider. Notice to the Member must be provided by the later of thirty (30) Calendar Days prior to the effective date of the termination, or fifteen (15) Calendar Days after receipt or issuance of the termination notice.

5.6.7.5 Members with Appeals in Process

The CONTRACTOR shall ensure the continuation of the Member's Benefits/services while an Appeal is in process if all of the conditions in Section 9 are satisfied and consistent with Federal Regulations (42 CFR § 438.420(a); 42 CFR § 438.420(b)).

5.7 Care Coordination and Case Management for Members Enrolled in Foster Care

In addition to all other requirements in this section of the contract, the CONTRACTOR will develop specific policies and procedures for the Care Coordination and Case Management activities for Members enrolled in Foster Care.

5.7.1 General Requirements- Annual Program Description

The CONTRACTOR shall:

5.7.1.1 Submit a Care Coordination and Case Management Program Description annually to SCDHHS which shall also include an evaluation of the program from the previous year, highlighting achievements, lessons learned and strategies for improvement. The Program Description May be submitted within the existing Program Description that is submitted annually as long as Foster Care specific information is separately identifiable.

5.7.1.2 Care Coordination and Case Management Activities for Members enrolled in Foster Care is not limited to, but shall include the following requirements:

The CONTRACTOR shall:

5.7.1.2.1 Identify health conditions that require prompt medical attention such as acute illnesses, chronic diseases requiring therapy, identify signs of abuse or neglect, signs of infection or communicable diseases, nutritional or dental problems, pregnancy, and significant developmental or mental health disturbances. In addition, Contractor shall assist in identifying health conditions that should be considered in making placement decisions.

5.7.1.2.2 Collaborate with other state agencies and foster parents to ensure initial physical and behavioral health assessments are completed within an agreed upon timeframe.

5.7.1.2.3 Collect historical behavioral and medical health data about the child from available claims data.

5.7.1.2.4 Review immunization status and recommend any needed follow up.

5.7.1.2.5 Send welcome packets about the CONTRACTOR’s services to foster parents and caseworkers.

5.7.1.2.6 Connect with foster parent to inform them of the CONTRACTOR’s benefits and offer to assist in making required initial comprehensive medical appointment and dental exam with the Member’s preferred provider.

5.7.1.2.7 Have policies and procedures for monitoring that Members are receiving required care.

5.7.1.2.8 Notify DSS/parent/guardian of medical necessity denials.

5.7.1.2.9 Make available, information to Member, regarding the availability of emergency services and after-hours availability.

5.7.1.2.10 Track network adequacy issues and report concerns to SCDHHS regarding network changes that may have an impact to foster care children.

5.7.1.2.11 Participate in DSS casework training.

5.7.1.2.12 Have procedures in place to facilitate communication with DSS about the health status of foster care children.

5.7.1.2.13 Cooperate with SCDHHS on the monitoring of the Care Coordination and Case Management program to include Corrective Action when policies and procedures are found to be out of compliance.

Section 6. NETWORKS

6.1 General Medicaid Managed Care Program Network Requirements

In accordance with 42 CFR § 438.206, the CONTRACTOR must ensure that it possesses a network of Providers sufficient to provide adequate access to all services covered under this contract. In the development and maintenance of its Provider network, at a minimum, the CONTRACTOR must meet the requirements outlined throughout this Section of this contract and all applicable manuals.

The CONTRACTOR shall meet the following requirements:

6.1.1 Consider anticipated Medicaid Enrollment.

6.1.2 Consider expected utilization of services, taking into consideration the characteristics and health care needs of the specific Medicaid Member populations represented in a Department approved Geographical Service Area.

6.1.3 Consider the number and types of Providers required, in terms of training, experience, languages spoken, number of network Providers accepting new Managed Care Members, number of available spaces on Provider panels, and specialization to furnish the contracted Medicaid services;

6.1.4 Consider the geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

6.1.5 Provide female Members with direct access to a women's health specialist within the network for covered care necessary to provide routine and preventive health care services. This is in addition to the Member’s designated source of primary care if that source is not a women's health specialist.

6.1.6 Provide for a second opinion from a qualified Health Care Professional within the network or arranges for the Member to obtain one outside the network, at no cost to the Member.

6.1.7 Demonstrate that its Providers are credentialed as required by 42 CFR § 438.214 and this contract.

6.1.8 Ensure that all contracted Providers are South Carolina Medicaid Enrolled Providers by verifying ongoing Medicaid Enrollment with the Department through the utilization of the daily Provider Junction File.

6.1.9 Obtain prior written approval from the Department for Provider communications that reference Departmental policies or procedures.

6.1.10 Not discriminate with respect to participation, reimbursement, or indemnification as to any Provider, whether participating or nonparticipating, who is acting within the scope of the Provider's license or certification under applicable state law, solely based on such license or certification, in accordance with § 1932(b) (7) of the Social Security Act when developing its network.

6.1.10.1 The CONTRACTOR shall not discriminate with respect to participation, reimbursement, or indemnification of any provider who services high-risk populations or specializes in conditions that require costly treatment.

6.1.10.2 If the CONTRACTOR declines to include individual or groups of Providers, it must give written notice of the reason for its decision per 42 CFR § 438.12(a) and (b), and may not be construed to:

6.1.10.2.1 Require the CONTRACTOR to contract with Providers beyond the number necessary to meet the needs of its Members;

6.1.10.2.2 Preclude the CONTRACTOR from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

6.1.10.2.3 Preclude the CONTRACTOR from establishing measures that are designed to maintain quality of services and controls costs and are consistent with its responsibilities to Members.

6.1.11 Furnishing of Services

The CONTRACTOR shall ensure timely access by:

6.1.11.1 Meeting with and requiring its Providers to meet any Federal, State, or Departmental standards for timely access to care and services, considering the urgency of the need for services.

6.1.11.2 Ensuring its network Providers offer hours of operation that are no less than the hours of operation offered to commercial Members or comparable to Medicaid FFS, if the Provider serves only Medicaid Managed Care Members.

6.1.11.3 Ensuring all services included in the contract are made available twenty-four (24) hours a day, seven (7) Days a week, when medically necessary.

6.1.11.4 Establishing mechanisms to ensure compliance by Providers.

6.1.11.5 Monitoring Providers regularly to determine compliance.

6.1.11.6 Taking corrective action if there is a failure to comply.

6.1.12 Cultural Considerations

The CONTRACTOR shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

6.2 CONTRACTOR Provider Network

The CONTRACTOR shall establish and maintain, through written agreements, an appropriate Provider network necessary for the provision of the services under this contract; this includes, but is not limited to, primary care Providers (PCPs), specialty Providers, hospitals and other health care service Providers as identified by the Department. For geographic areas lacking Providers sufficient in number,

mix, and geographic distribution to meet the needs of the number of members in the Service Area, the Department at its sole discretion may waive requirements.

Providers are designated a status based upon taxonomy as outlined in the Network Adequacy Chart found in the Managed Care Report Companion Guide. The Department has four status designations that inform access and adequacy requirements. Any changes to a Provider's status designation shall be at the sole discretion of the Department.

6.2.1 Status One (1) Providers

Status One providers are South Carolina Medicaid network Providers that the Contractor is required to have an executed contract with. These providers have defined adequacy standards.

6.2.1.1 Primary Care Providers (PCP)

6.2.1.1.1 Access Standards for Primary Care Providers

The CONTRACTOR shall:

6.2.1.1.1.1 Implement procedures to ensure that each Member has a person or entity, formally designated, as a PCP, primarily responsible for coordinating their health care services.

6.2.1.1.1.2 Ensure each Member has access to at least one PCP with an open panel.

6.2.1.1.1.3 Ensure its contracted PCPs have an appointment system that meets the following access standards:

6.2.1.1.1.3.1 Routine visits for established patients scheduled within f15 Business days.

6.2.1.1.1.3.2 Urgent, Non-Emergent visits within forty- eight (48) hours.

6.2.1.1.1.3.3 Emergent visits immediately upon presentation at a service delivery site.

6.2.1.1.1.3.4 Waiting times that do not exceed forty-five (45) minutes for a scheduled appointment of a routine nature.

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

6.2.1.1.1.3.6 Provide twenty-four (24) hour coverage by direct access or through arrangement with a triage system.

6.2.1.1.1.4 Monitor the adequacy of its appointment processes.

6.2.1.1.2 Adequacy Standards for Primary Care Providers

6.2.1.1.2.1 Urban Core County: For Providers acting in the capacity of a primary care Physician the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) PCP within twenty (20) miles and within twenty (20) minutes or less driving time.

6.2.1.1.2.2 Urban Influenced County: For Providers acting in the capacity of a primary care Physician the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) PCP within twenty-five (25) miles and within twenty-five (25) minutes or less driving time.

6.2.1.1.2.3 Rural Isolated County: For Providers acting in the capacity of a primary care Physician the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) PCP within twenty-five (25) miles and within twenty-five (25) minutes or less driving time.

6.2.1.2 State Focus Providers

Those providers that are defined as obstetrician and gynecologists (OB-GYN), Licensed Mental Health Professionals (LMHP), Retail Pharmacies, and Autism Services Providers.

6.2.1.2.1 Access Standards for State Focus Providers

The Contractor shall:

6.2.1.2.1.1 Ensure routine visits for established patients are scheduled within 15 business days.

6.2.1.2.1.2 Ensure urgent, Non-Emergent visits are within forty- eight (48) hours.

6.2.1.2.1.3 Ensure its contracted State Focus Providers have an appointment system that meets the following access standards:

6.2.1.2.1.3.1 Emergent visits immediately upon presentation at a service delivery site.

6.2.1.2.1.3.2 Waiting times that do not exceed forty-five (45) minutes for a scheduled appointment of a routine nature.

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

6.2.1.2.1.3.4 Provide twenty-four (24) hour coverage by direct access or through arrangement with a triage system.

6.2.1.2.1.4 The CONTRACTOR shall monitor the adequacy of its appointment processes.

6.2.1.2.2 Adequacy Standards for State Focus Providers

6.2.1.2.2.1 Urban Core County: For State Focus providers the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) required specialist within twenty-five (25) miles and within twenty-five (25) minutes or less driving time.

6.2.1.2.2.2 Urban Influenced County: For State Focus providers the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) required specialist within thirty (30) miles and within thirty-five (35) minutes or less driving time.

6.2.1.2.2.3 Rural Isolated County: For State Focus providers the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) required specialist within thirty-five (35) miles and within forty (40) minutes or less driving time.

6.2.1.3 Required Specialists

Required Specialists shall include all remaining Status 1 Providers not covered under PCPs, State Focus Providers, or Hospitals.

6.2.1.3.1 Access Standards for Required Specialists

The CONTRACTOR shall:

6.2.1.3.1.1 Be required to contract with required specialists based on the standards outlined within this contract.

6.2.1.3.1.2 Ensure each Member has access to Specialists with an open panel.

6.2.1.3.1.3 Accept the Department's instruction to include additional specialists for a specific geographic area, when necessary.

6.2.1.3.1.4 For specialty referrals, provide for:

6.2.1.3.1.4.1 Emergent visits immediately upon referral.

6.2.1.3.1.4.2 Urgent medical condition care appointments within forty-eight (48) hours of referral or notification of the Primary Care Physician.

6.2.1.3.1.4.3 Scheduling of appointments for routine care (non-symptomatic) within four (4) weeks and a maximum of twelve (12) weeks for unique specialists.

6.2.1.3.1.4.4 Out of network Indian Health Care Provider referrals of an Indian member to an In Network Provider.

6.2.1.3.2 Adequacy Standards for Required Specialists

6.2.1.3.2.1 Urban Core County: For Required Specialists the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) required specialist within ~~fifty~~ forty (40~~50~~) miles and within forty-five (45) minutes or less driving time.

6.2.1.3.2.2 Urban Influenced County: For Required Specialists the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) required specialist within fifty (50) miles and within sixty (60) minutes or less driving time.

6.2.1.3.2.3 Rural Isolated County: For Required Specialists the standard is 90% of the Managed Care Eligible population in the county must have access to at least one (1) required specialist within fifty (50) miles and within sixty (60) minutes or less driving time.

6.2.1.4 Hospitals

6.2.1.4.1 Access Standards for Hospitals

The CONTRACTOR shall:

6.2.1.4.1.1 Ensure hospital Providers are qualified to provide services under the Medicaid Program.

6.2.1.4.1.2 Ensure each of the CONTRACTOR's Members have access to hospitals.

6.2.1.4.2 Adequacy Standards for Hospitals

6.2.1.4.2.1 Urban Core County: For hospitals, the standard is 90% of the Managed Care Eligible population in the county must have access to a hospital within thirty-five (35) miles and within forty-five (45) minutes or less driving time.

6.2.1.4.2.2 Urban Influenced County: For hospitals, the standard is 90% of the Managed Care Eligible population in the county must have access to a hospital within fifty (50) miles and within sixty (60) minutes or less driving time.

6.2.1.4.2.3 Rural Isolated County: For hospitals, the standard is 90% of the Managed Care Eligible population in the county must have access to a hospital within fifty (50) miles and within seventy (70) minutes or less driving time.

6.2.2 Status Two (2) Providers

6.2.2.1 All Status Two (2) Providers shall be considered Required Providers as defined above.

6.2.2.2 The Contractor shall have an executed contract with all Status Two (2) Providers.

6.2.2.3 Distance and drive time requirements are not considered for network adequacy for Providers with a Status Two (2) designation.

6.2.3 Status Three (3) Providers

6.2.3.1 The Contractor shall provide Status Three (3) Provider services through any means necessary. While the Contractor may attest to status three (3) services, a Contract is not required when the Contractor's reimbursement to the Provider is at or above the established Medicaid fee schedule for the date of service.

6.2.3.2 A Contract is required should the Contractor choose to compensate at a rate less than the Medicaid fee schedule for the date of service.

6.2.3.3 Allow the Member to choose a Nurse Practitioner (NP) to provide the health care services allowed within their scope of services. Members shall not be automatically assigned to a NP. NPs submitted on the Provider file to the Enrollment broker must be coded to allow Member choice only.

6.2.4 Status Four (4) Providers

6.2.4.1 Status Four (4) Providers are those Providers who offer Additional Services that are not Core Benefits as defined in *Section 4* of this Contract to include, but not limited to, Case Management, Dental, HCBS, and Hospice Services. Such services shall comply with the terms of the Policies and Procedures, and contract between the Department and the Contractor.

6.2.4.2 The Contractor shall reimburse for all services provider to Members by Status Four (4) Providers.

6.3 Provider Network Submission

The CONTRACTOR shall:

6.3.1 Submit its Provider network to the Department quarterly in accordance with this contract and as detailed in the Managed Care Report Companion Guide.

6.3.2 Ensure that each network submission reflects actively enrolled South Carolina Medicaid Network Providers, in good standing, and eligible for payment through the Medicaid Managed Care program.

6.3.3 Ensure the submission is submitted with the required data as specified in the Managed Care Report Companion Guide.

6.3.4 Ensure the submission reflects the CONTRACTOR's entire contracted South Carolina Medicaid Provider network. The submission shall be due as specified by the Department, but no less frequently than:

6.3.4.1 No later than ninety (90) Days prior to the intended start date for a new CONTRACTOR or entry of any CONTRACTOR into a new geographic area;

6.3.4.2 Quarterly thereafter, on April 15 reflecting the Contractor's network as of March 31, July 15 reflecting the CONTRACTOR's network as of June 30, October 15 reflecting the Contractor's Network as of September 30, and on January 15 reflecting the CONTRACTOR's network as of December 31;

6.3.4.3 The CONTRACTOR shall notify the Department of any pending significant change to their network within five (5) Business Days of provider notification.

6.3.4.3.1 Significant changes in the network are defined as changes that would affect adequate capacity and services for the CONTACTOR's Members. These changes include changes in services, Benefits, geographic area, or Enrollment of a new population in CONTRACTOR's Health Plan, or a Provider termination.

6.3.4.3.2 The CONTRACTOR shall submit a network adequacy report no later than sixty (60) Days prior to the effective date of the change.

6.4 Provider Network Submission Assessment

The department shall utilize the results of each network submission to determine the adequacy of the CONTRACTOR's Provider network.

The CONTRACTOR shall:

6.4.1 Respond in writing to the Department for all instances where the assessment reflects a failure for a Provider specialty and count and/or the presence of non-enrolled providers on the Provider Network Submission.

6.4.2 The Network Analysis will assess the CONTRACTORs network adequacy utilizing a Pass/Fail rating. For all network failures found on the report the Contractor's response to the Department must include a plan of action for addressing the assessment failure.

6.4.2.1 The plan of action must address and reduce the failure by the next network assessment

6.4.3 If the network failure remains after the second assessment of network adequacy the Department will enact the provisions indicated in *Section 18* of this contract.

6.4.4 If the network failure remains after the third assessment of network adequacy the Department may enact additional measures including the network termination/transition process indicated in *Section 17* and *Section 18* of this Contract.

6.5 Non-Participating Providers

The CONTRACTOR shall:

6.5.1 If the CONTRACTOR's network is unable to provide Medically Necessary Core Benefits to a particular Member, the CONTRACTOR shall adequately cover these services. The CONTRACTOR must inform the Non-Participating Provider that that the Member cannot be balance billed.

6.5.2 The CONTRACTOR shall coordinate with Non-Participating Providers regarding payment for services. For payment to Non-Participating Providers the following guidelines apply:

6.5.2.1 If the CONTRACTOR offers the service through an In Network Provider and the Member chooses to access the service from a Non-Participating Provider, the CONTRACTOR is not responsible for payment.

6.5.2.2 If the service is not available from an In Network Provider and the Member requires the service and is referred for treatment to a Non-Participating Provider reimbursement is determined by the CONTRACTOR and Non-Participating Provider.

6.5.2.3 If the service is not available from an In Network Provider, but the CONTRACTOR has three (3) documented attempts to contract with a Non-Participating Provider, the CONTRACTOR may reimburse that Provider less than the Medicaid Fee for Service rate.

6.5.2.4 If the service is available from a Non-Participating Provider, but the service meets the level of emergency services and the CONTRACTOR has three (3) documented attempts to contract with the Provider, the CONTRACTOR may reimburse less than the Medicaid Fee for Service rate.

6.6 Annual Network Development Plan

6.6.1 The CONTRACTOR shall develop and maintain an annual network development plan and shall submit this plan by September 1 of each Contract year, to the Department.

6.6.2 The CONTRACTOR's annual network development plan shall include:

6.6.2.1 The CONTRACTOR's in-depth processes and methods to develop, maintain, and monitor an appropriate provider network that is sufficient to provide adequate access to all services covered under this Contract.

6.6.2.2 The CONTRACTOR's annual network development plan must include a description of network design for each population served by the Managed Care Plan.

6.6.2.3 The CONTRACTOR's annual network development plan must include a description or explanation of the current status of the network by each covered service at all levels, including:

6.6.2.3.1 Immediate short-term interventions to address network gaps, including the process for enrollees to access services;

6.6.2.3.2 Long-term interventions to resolve network gaps and an evaluation of the effectiveness of those interventions to resolve network gaps and barriers;

6.6.2.3.3 Method for accessing a non-participating provider to address any potential gaps, including a description of the CONTRACTOR's provider outreach strategy;

6.6.2.3.4 The extent to which the CONTRACTOR utilizes telemedicine services to resolve network gaps;

6.6.2.3.5 Ongoing activities for network development, including network management functions delegated to subcontractors.

6.6.2.3.6 The assistance and communication tools provided to PCPs when they refer Members to specialists and the methods used to communicate the availability of this assistance to the providers;

6.6.2.3.7 Pharmacy features such as the availability of independent, compounding, mail order, and home delivery pharmacy services.

6.6.2.4 The CONTRACTOR's annual network development plan must include an organizational flowchart that outlines relationships between internal departments, including all committees and committee membership, by department/area, where this coordination occurs.

6.6.2.5 The CONTRACTOR's annual network development plan shall include a description of coordination with provider associations and other outside organizations.

6.6.2.6 The CONTRACTOR's annual network development plan shall include a description of the overall monitoring strategy of subcontractors delegated for network management functions, including how those monitoring results are used to ensure continuous oversight across all provider network functions between the CONTRACTOR and its subcontractors.

6.6.2.7 The CONTRACTOR's annual network development plan shall include a description of the evaluation of the prior year's plan including an explanation of the method used to evaluate the network and reference to the success of proposed interventions and/or the need for re-evaluation.

Section 7. PAYMENTS

7.1 Financial Management

The CONTRACTOR shall:

7.1.1 Be responsible for sound fiscal management of the health care plan developed under this contract.

7.1.2 Designate an internal auditor that shall ensure compliance with adopted standards and review expenditures for reasonableness and necessity.

7.2 Medical Loss Ratio (MLR)

7.2.1 General MLR Requirements

Pursuant to 42 CFR §§ 438.4, 438.5, 438.8, 438.74, the CONTRACTOR must comply with the federal and state-established Medical Loss Ratio (MLR) standards.

The CONTRACTOR shall:

7.2.1.1 Maintain an annual (SFY July 1 – June 30) Medical Loss Ratio (MLR) of eighty-six percent (86%) for the contract term (July 1, 2024 – June 30, 2027) (42 CFR 438.8(c)).

7.2.1.2 Comply with the federal and state-level MLR calculation methodologies outlined within this Section of this contract, the Managed Care Report Companion Guide, the CMCS Informational Bulletin issued May 15, 2019 related to third-party vendors, and any other MLR-related guidance published by the Department during this contract period (42 CFR § 438.8(d)).

7.2.1.3 Aggregate data for all Medicaid eligibility groups covered under this contract unless the Department requires separate reporting and a separate MLR calculation for specific populations.

7.2.1.4 Include all numerator and denominator elements defined within 42 CFR § 438. 8(e), 438.8(f) and further outlined within this Section of this contract, the Managed Care Report Companion Guide, and any other MLR-related guidance published by the Department during this contract period.

7.2.1.5 Provide a remittance for an MLR reporting year if the MLR for the MLR reporting year does not meet the minimum MLR standard of eighty-six percent (86%) (See 42 CFR § 438.8(j)). The remittance amount shall be determined using the CMS MLR calculation methodology defined as the ratio of the numerator (as defined in accordance with 42 CFR § 438.8(e) excluding state-directed payments with separate payment terms) to the denominator (as defined in accordance with 42 CFR § 438.8(f) excluding state-directed payments with separate payment terms).

7.2.1.6 Submit an initial report to the Department which includes all information included in 42 CFR § 438.8(k) within ten (10) months of the end of the MLR reporting year defined as State Fiscal Year (SFY) and attest to the accuracy of the calculation of the MLR.

7.2.1.7 Submit a final MLR report to the Department which includes all information included in 42 CFR § 438.8(k) and 42 CFR § 438.8(n) within twenty-two (22) months of the end of the MLR reporting year defined as State Fiscal Year (SFY) and attest to the accuracy of the calculation of the MLR.

7.2.1.8 In accordance with 42 CFR § 438.8(k)(3), require any Third Party vendor providing Claims adjudication activities to provide all underlying data associated with MLR reporting to the CONTRACTOR within one hundred eighty (180) Days of the end of the MLR reporting year or within thirty (30) Days of being requested by the CONTRACTOR, whichever comes sooner, regardless of current contractual limitations, to calculate and validate the accuracy of MLR reporting.

7.2.1.9 The Contractor shall adhere to all federal requirements as it relates to allocation of expenses for MLR and as outlined in 42 CFR 438.8(g).

7.2.1.10 Provide Claim-level pharmacy reimbursement detail, reflecting the amount paid by the Pharmacy Benefit Manager (PBM) to the pharmacy Provider, in the format required by the Department. Upon request, the CONTRACTOR shall provide all information necessary for the Department to evaluate compensation received by the CONTRACTOR's Pharmacy Benefits Manager (PBM). This information includes access specific to the South Carolina Medicaid Managed Care Program including:

7.2.1.10.1 Aggregate sums of rebates received for utilization related to the CONTRACTOR's pharmacy Claims.

7.2.1.10.2 Aggregate sums of payments to pharmaceutical manufacturers and/or Third Parties for administrative services related to Medicaid Members prescription drug utilization.

7.2.1.10.3 Aggregate sums of reimbursements or reimbursement offsets to pharmacy providers not otherwise accounted for in this section of the contract.

7.2.1.10.4 Data provided to the Department by the CONTRACTOR pursuant to this section of the contract shall be held in confidence by the Department to the extent allowed by law and will not be disclosed in a manner to identify individual providers, to the extent allowed by law.

7.2.1.11 Report annually on any fees (e.g., transactions fees, etc.) charged by PBMs to contracted network pharmacies, in the format required by the Department.

7.2.2 Medical Loss Ratio (MLR) Calculations

The MLR Calculation shall be aligned with federal standards during the term of this contract; however, the Department reserves the right to incorporate additional state-specific criteria for MLR calculations.

The CONTRACTOR shall:

7.2.2.1 Demonstrate ongoing compliance by completing and submitting appropriate financial reports, as specified in various MLR reporting requirement provisions found within this contract, the Reports Companion Guide and any other MLR-related Managed Care contract provision guidance published by the Department during this contract period. The Department will provide additional guidance to CONTRACTORs, as appropriate, to ensure that the CONTRACTOR adheres to all relevant federal and state requirements.

7.2.2.2 Incorporate any credibility adjustments to the MLR Calculation in accordance with 42 CFR 438.8(h). Should the Contractor's MLR reporting year experience be deemed non-credible, it is presumed to meet or exceed the MLR calculation standards.

7.2.3 MLR Calculation Formula

In addition to the provisions set forth in 42 CFR §§ 438.4, 438.5, 438.8, 438.74, and those found within this contract, the Reports Companion Guide and any other MLR-related Managed Care contract provision guidance published by the Department, the following formula, as defined in accordance with 42 CFR § 438.8 , represents the basic MLR calculation formula for the term of this contract (July 1, 2024 to June 30, 2027):

7.2.3.1 Numerator: (All elements required under 42 CFR § 438(e)) The CONTRACTOR must include quality improvement activities in the MLR calculation as follows:

7.2.3.1.1 Up to two percent (2.0%) of premium revenue for MCO’s with an NCQA Medicaid South Carolina Health Insurance Plan rating with a value of three (3.0) or less for the NCQA rating release coincident with the MLR measurement period.

7.2.3.1.2 Up to two and one-half percent (2.5%) of premium revenue for MCO’s with an NCQA Medicaid South Carolina Health Insurance Plan rating with a value of three and one-half (3.5) for the NCQA rating release coincident with the MLR measurement period.

7.2.3.1.3 No limitation of premium revenue for MCO’s with an NCQA Medicaid South Carolina Health Insurance Plan rating with a value of four (4.0) or greater for the NCQA rating release coincident with the MLR measurement period.

7.2.3.1.4 NCQA ratings are released every September and are based on data from prior year(s). NCQA rating release in 2024 will be used for the MLR measurement period of SFY 2025; NCQA rating release in 2025 will be used for the MLR measurement period of SFY 2026; NCQA rating release in 2026 will be used for the MLR measurement period of SFY 2027.

7.2.3.2 Denominator: (All elements required under 42 CFR § 438.8(f)).

7.2.4 Return of Funds

7.2.4.1 The CONTRACTOR understands and agrees that the CONTRACTOR must provide remittance to the Department for an MLR reporting year if the MLR for that reporting year does not meet the requirements stated in *Section 7.2.1.5*.

7.2.4.2 In the event of a change in the capitation rate for each MLR reporting period stipulated within this contract, a MLR calculation—in accordance with the requirements of this Provision, 42 CFR § 438.8(m), and 42 CFR § 438.8(k)—shall be re-determined by the Department.

7.2.4.3 Subsequent to this re-determination, adjustments to payments in accordance with this provision may result in changes in payment by the CONTRACTOR to the Department.

7.3 Capitation Payments from the Department to CONTRACTOR

7.3.1 Capitation Payments

The Department develops capitation payments using an actuarially sound methodology in accordance with 42 CFR § 438.4. The resulting rates are certified annually and submitted to CMS for approval. Methodologies are detailed in the Managed Care Rate Certification Book.

7.3.1.1 If federal authority is withdrawn for any part of the scope of work under this contract, the Department may elect to supplement federally approved Capitation Payments with funds from other sources.

7.3.1.2 The Department shall perform Managed Care Capitation Payment certifications that will require the CONTRACTOR to provide reports detailed in the Managed Care Report Companion Guide.

7.3.1.3 The Department agrees to make, and the CONTRACTOR agrees to accept the Capitation Payments, as outlined in *Appendix B*, and any other authorized payments, as payment in full for all services provided to Members pursuant to this contract. (42 CFR § 438.3(c)(2))

7.3.1.4 The Capitation Payment is equal to the monthly number of Members in each category multiplied by the capitation rate established for each category per month plus a Maternity Kicker payment for each Member who delivers during the month.

7.3.1.5 Irrespective of any third-party liability for the delivery or its component parts, the Manual Maternity Kicker payment will be paid to the Contractor as outlined in the Managed Care Report Companion Guide.

7.3.1.6 To the extent there are material changes, as determined by the Department, to the Medicare fee schedule and subsequent changes to the Medicaid fee schedule during the contract period, the Department reserves the right to adjust the Capitation Payments accordingly.

7.3.1.7 No more frequently than once during each Department fiscal year (a.k.a. state fiscal year (SFY); July 1st to June 30th), the Department reserves the right to defer remittance of the Capitation Payment to the CONTRACTOR.

7.3.1.7.1 The Department shall notify the CONTRACTOR of such deferral at least fourteen (14) Business Days prior to the expected payment date.

7.3.1.7.2 The Department may defer the Capitation Payment for a period not longer than thirty-three (33) Calendar Days from the original payment date to comply with the Department's fiscal Policies and Procedures.

7.3.1.8 In the event the federal government lifts any moratorium on supplemental payments to Physicians or facilities, capitation rates in this contract will be adjusted accordingly.

7.3.1.9 The Department shall implement a cost-neutral PRTF risk pool each fiscal year described in the agencies annual rate certification book.

7.3.1.10 The Department, upon learning of a Member's retroactive enrollment into Medicare, shall recoup any funds that are identified as the responsibility of the primary payor during the retroactive review period.

7.3.2 Inaccurate Member Payments

7.3.2.1 In the event that the Department pays a Provider a FFS payment for services which are covered under the CONTRACTOR's Capitation Payment, when those services were provided to a Member during the time frame the Member was enrolled or retroactively enrolled in the CONTRACTOR's Health Plan, the Department shall withhold from the CONTRACTOR an amount equal to the FFS payment(s).

7.3.2.2 The Contractor shall maintain responsibility to reconcile the "gross-level" adjustments sent to the Contractor. Gross level adjustments completed by Department shall be made based on the premium payment made for each Member at the monthly cutoff date.

7.3.2.3 If the Department determines premium reconciliation is required, the Department shall initiate an adjustment. The Contractor shall only initiate claim Recoupment Procedures for adjusted premiums reflected in the monthly reports provided by the Department for those cases in which retrospective review and recoupment is necessary. The Contractor should contact their Department Contract Monitor to report any possible discrepancies. Refer to the Managed Care Report Companion Guide for additional information. For the purposes of this section, notification from the Department shall be defined as the date on which the Department delivers the applicable monthly report(s) to the Contractor. All notification requirements in this section shall be based on this delivery date.

7.3.2.3.1 Dual Eligible Members

Upon notification of Medicare enrollment, the Contractor shall recoup Provider payments in accordance with the Code of Federal Regulations. The Contractor shall notify Providers within sixty (60) Days and initiate

Recoupment Procedures where the Contractor was paid as the primary payer.

7.3.2.3.2 Capitation Payments made for Deceased Members

In instances in which a Capitation Payment may be made by the Department in error for Members that have passed away, the Department shall seek to recoup the Capitation Payment that was made.

7.3.2.3.3 Capitation Payments made for Waiver and Hospice Members

In instances in which a Capitation Payment was be made by the Department prospectively for Members that are moved to one of the SCDHHS Home and Community Based Waivers or Hospice services, the Department shall seek to recoup the Capitation Payment that was made for months when the Member was eligible for either program. Provider adjustments shall be initiated by the Contractor within six (6) months of the notice from the Department.

7.3.3 Payments for Unauthorized Work

Should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the CONTRACTOR must do no work on that part after the effective date of the loss of program authority. The Department must adjust capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the CONTRACTOR works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the CONTRACTOR will not be paid for that work. If the state paid the CONTRACTOR in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the CONTRACTOR worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the CONTRACTOR, the CONTRACTOR may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

7.4 Payments from CONTRACTOR to Providers

7.4.1 State-Directed Payments

In compliance with 42 CFR 438.6(c), the South Carolina Managed Care capitation rate certification reflects the following delivery system and provider payment initiatives:

7.4.1.1 Supplemental Teaching Physician Program

The Capitation Payment to the CONTRACTOR includes a directed payment program for teaching physician payments. South Carolina supplemental teaching physician Providers are teaching physicians providing professional services employed by or under

contract with a South Carolina public medical university, academic medical center and/or its component units or an SC Area Health Education Consortium (AHEC) Teaching Health System. An SC AHEC Teaching Health System is defined as a health system with at least one teaching hospital sponsoring a Family Medicine Residency Program under contract with the Medical University of South Carolina through the sponsorship of the SC AHEC Graduate Medical Education Agreement. All teaching physicians must have faculty appointment or a teaching physician agreement with one of the following entities:

The Medical University of South Carolina (MUSC)
The University of South Carolina School of Medicine (USC)
An SC AHEC Teaching Health System as defined above

7.4.1.1.1 The CONTRACTOR shall make payments for the teaching physician directed payment program based on the Department's instructions and reporting issued on a quarterly basis. Teaching Physician Directed Payments shall be made by each Contractor directly to the academic medical center indicated in the quarterly report.

7.4.1.1.2 Payments shall be made to the indicated academic medical center within thirty (30) calendar days of the report being issued to and remittance being received by the Contractor.

7.4.1.1.2.1 Once payment has been issued, the Contractor shall notify the Department by submitting a release of funds attestation signed by the Contractor's Chief Financial Officer (CFO) or Chief Executive Officer (CEO) on Contractor letterhead.

7.4.1.1.3 The dollars associated with the teaching directed payment shall be outlined in the annual Capitation Payment certification. The state directed payment is incorporated into the capitation rates as a separate payment term. These directed payment arrangements are in accordance with 42 CFR. § 438.6(c)(2)(ii)(F) and are not renewed automatically.

The CMS control name for this approved State Directed Payment Program covering the rating period July 1, 2024 – June 30, 2025 (SFY 2025) is SC_Fee_AMC_Renewal_20240701-20250630:

For SFY 2026 the Department has submitted a preprint for approval to renew this State Directed Payment Program under the CMS control number SC_Fee_AMC Renewal_20250701-20260630 (SFY2026).

7.4.1.2 Rural Hospital Minimum Fee Schedule

The CONTRACTOR shall reimburse all in-network South Carolina rural hospitals defined under the Medicaid State Plan (including hospitals that are or become designated as Rural Emergency Hospitals) no less than the applicable Medicaid State Plan rate ("rate floor") for inpatient and outpatient services (as allowed under 42 CFR §

438.6(c)(1)(ii)(A)), and utilize the applicable Fee-for-Service payment methodology, unless the CONTRACTOR and hospital have mutually agreed to a higher reimbursement amount or methodology.

The applicable rate floor and methodology for inpatient and outpatient hospital services shall be one hundred percent (100%) of the applicable hospital-specific Medicaid Fee-for-Service reimbursement rate based on 100% of the Medicaid inpatient and outpatient hospital-specific costs incurred. This state directed payment program is considered as part of the monthly capitation rates paid to the CONTRACTOR.

7.4.1.2.1 The CONTRACTOR shall offer a Provider agreement to all hospitals qualifying for the rate floor as defined in this section and obtain the Department's written approval prior to terminating the Provider agreement.

7.4.1.3 Health Access, Workforce, and Quality (HAWQ)

The Department seeks to provide enhanced support to hospitals to preserve and enhance access to those facilities that deliver essential services to Medicaid Members in South Carolina HAWQ is a directed payment program to preserve and promote access to medical services through an increase in the amounts specified by the Department to the CONTRACTOR's reimbursement to contracted hospitals.

The Department shall compute the annual interim HAWQ uniform payment rate increase percentage using projected experience for the contract period and will pay out twenty-five percent (25%) of the total on a quarterly basis. Lump sum payments made outside of monthly capitation will be sent to the CONTRACTOR with payment directions.

No later than twelve (12) months after the end of the contract period, the Department intends to adjust final HAWQ payment amounts by the CONTRACTOR and provider based on actual utilization incurred and will direct the CONTRACTOR to adjust payments at that time. The Department may amend the HAWQ components annually and will provide guidance to the CONTRACTOR as applicable.

HAWQ payments are intended to supplement, not supplant, payments to hospitals. The CONTRACTOR may not reduce contracted rates because of HAWQ. These directed payments arrangements are in accordance with 42 C.F.R. § 438.6(c)2(ii)(F) and are not renewed automatically. This State Directed Payment Program was approved by CMS for SFY 2025 covering the rating period of July 1, 2024 -June 30, 2025 under CMS control number SC_Fee_IPH.OPH_Renewal_20240701-20250630. The Department has submitted a preprint to CMS for renewal of this State Directed Payment under CMS control number SC_Fee_IPH.OPH_Renewal_20250701-20260630.

7.4.1.3.1 Payments from the Contractor shall be completed within thirty (30) calendar days of the delivery of the reports and remittance of the lump sum payments from the Department.

7.4.1.3.2 Once the Contractor has issued the payment, the Contractor shall notify the Department by submitting a release of funds attestation signed by the Contractor's Chief Financial Officer or Chief Executive Officer on the Contractor's letterhead.

7.4.1.4 Independent Community Pharmacy Directed Payment Program

For the SFY 2025 contract period, under the CMS approved control number SC_Fee_Oth_Renewal_20240701-06302025, and a renewal of this State Directed Payment Program for SFY 2026 under the approved CMS Control number SC_Fee_Oth_Renewal_20250701 – 20260630 the Department seeks to provide enhanced support to pharmacy providers that are designated as an Independent Community Pharmacy by the South Carolina Board of Pharmacy and ensure that Members have access to care and a quality experience of care. The Department shall utilize a uniform dollar increase to pay an additional dispensing fee for all prescriptions dispensed to Members by an In Network Independent Community Pharmacy. Such payment shall be incorporated into the capitation rates as a separate payment term to the Contractor.

The Department shall compute the first three (3) quarterly interim directed payment amounts using projected SFY 2025 experience with a final quarter of payment as a reconciliation of the first three (3) quarterly interim payments using actual SFY 2025 utilization. The reconciliation payment will be calculated approximately three (3) months after the end of the contract year. Lump sum payments made outside of monthly capitation will be sent to the CONTRACTOR with payment directions at the end of each quarter.

These directed payment arrangements in accordance with 42 CFR § 438.6(c)(2)(ii)(F) are not renewed automatically.

The same methodology has been approved under the SFY 2026 approved preprint cited above and will utilize the same payment and reconciliation schedule.

The Department shall compute the first three (3) quarterly interim directed payment amounts using projected SFY 2026 experience with a final quarter of payment as a reconciliation of the first three (3) quarterly interim payments using actual SFY 2026 utilization. The reconciliation payment will be calculated approximately three (3) months after the end of the contract year.

7.4.1.4.1 Payments from the Contractor shall be completed within thirty (30) calendar days of the delivery of the reports and remittance of the lump sum payments from the Department.

7.4.1.4.2 Once the Contractor has issued the payment, the Contractor shall notify the Department by submitting a release of funds attestation signed by the Contractor's Chief Financial Officer or Chief Executive Officer on the Contractor's letterhead.

7.4.1.5 Private Ambulance State Directed Payment

The Department shall implement a state directed payment program for emergency medical transport by ground non-governmental ambulance service providers who are enrolled as an active Medicaid provider with the Department and who provide services to eligible Members. The state directed payment will apply to the July 1, 2024 – June 30, 2025 (SFY 2025) rating period and will be effective January 1, 2025. The Department shall utilize a uniform percentage increase for the program and will make these payments to the CONTRACTOR by making two (2) interim payments and a final reconciliation payment. The reconciliation payment will be based on actual utilization of services paid for dates of service January 1, 2025 through June 30, 2025. The reconciliation payment will be calculated six (6) months after the end of the rating period to ensure appropriate run out. The state directed payment is included in the rate certification as a separate payment term. These directed payment arrangements, in accordance with 42 CFR § 438.6(c)(2)(ii)(F) are not renewed automatically. The CMS control name for this program is "SC_Fee_Oth3_20240701-20250630".

The Department has submitted and has been approved for a renewal of this State Directed Payment Program for SFY 2026 under CMS Control number SC_Fee_Oth3_Renewal_20250701 – 06302026.

The Department shall implement a state directed payment program for emergency medical transport by ground non-governmental ambulance service providers who are enrolled as an active Medicaid provider with the Department and who provide services to eligible Members. The state directed payment will apply to the July 1, 2025 – June 30, 2026 (SFY 2026) rating period and will be effective July 1, 2025. The uniform increase is paid in 5 disbursements, four quarterly interim payments and a reconciliation payment. The first four interim payments will be made at the end of each quarter in equal amounts calculated as one quarter of the payment pool less a 10% reserve amount. The reconciliation will be based on actual utilization of services paid during the period (dates of service July 1, 2025 - June 30, 2026) and will be calculated six months after the end of the rating period to allow for runout and ensure no overpayments are mad. The state directed payment is included in the rate certification as a separate payment term. These directed payment arrangements, in accordance with 42 CFR § 438.6(c)(2)(ii)(F) are not renewed automatically.

7.4.1.5.1 Payments from the Contractor shall be completed within thirty (30) calendar days of the delivery of the reports and remittance of the lump sum payments from the Department.

7.4.1.5.2 Once the Contractor has issued the payment, the Contractor shall notify the Department by submitting a release of funds attestation signed by the Contractor's Chief Financial Officer or Chief Executive Officer on the Contractor's letterhead.

7.4.1.6 Public Ambulance State Directed Payment Program

The Department shall implement a state directed payment program for emergency medical transport by ground public and government owned or operated ambulance

service providers who are enrolled as an active Medicaid provider with the Department and who provide services to eligible Members. The state directed payment will apply to the July 1, 2024 – June 30, 2025 (SFY 2025) rating period and will be effective January 1, 2025. The Department shall utilize a uniform dollar amount increase for the program and will make these payments to CONTRACTOR by making two (2) interim payments and a final reconciliation payment. The reconciliation payment will be based on actual utilization of services paid for dates of service January 1, 2025 through June 30, 2025. The reconciliation payment will be calculated six (6) months after the end of the rating period to ensure appropriate run out. The state directed payment is included in the rate certification as a separate payment term. These directed payment arrangements, in accordance with 42 CFR § 438.6(c)(2)(ii)(F) are not renewed automatically. The CMS control name for this program is "SC Fee Oth2_20240701-20250630".

The Department has submitted and been approved for a renewal of this State Directed Payment Program for SFY 2026 under CMS Control number SC_Fee_Oth2_Renewal_20250701 – 06302026.

The Department shall implement a state directed payment program for emergency medical transport by ground public and government owned or operated ambulance service providers who are enrolled as an active Medicaid provider with the Department and who provide services to eligible Members. The state directed payment will apply to the July 1, 2025 – June 30, 2026 (SFY 2026) rating period and will be effective July 1, 2025. The uniform increase is paid in 5 disbursements, four quarterly payments less and a reconciliation payment. The first four payments will be made at the end of each quarter in equal amounts calculated as one fourth of the payment pool less a 10% reserve amount. The reconciliation will be based on actual utilization of services paid during the period (dates of service July 1, 2025 – June 30, 2026) and will be calculated six-months after the end of the rating period to allow for run out and ensure no over payments are made. The state directed payment is included in the rate certification as a separate payment term. These directed payment arrangements, in accordance with 42 CFR § 438.6(c)(2)(ii)(F) are not renewed automatically.

7.4.1.7 SC Physician State Directed Payment Program

For the (SFY 2026) July 1, 2025 – June 30, 2026 rating period and upon CMS approval of preprint submission with the control name "SC_Fee_PC.Oth_New_20250701-20260630 the Department shall implement a state directed payment program that utilizes a minimum fee schedule for primary care services and pediatric subspecialty services that are provided by primary care providers and pediatric subspecialty providers. South Carolina Supplemental Teaching Physician ("STP") providers are not eligible for the enhanced rates under this State Directed Payment Program. Payment is made in addition to the negotiated rates between the Contractor and provider.

The state directed payment is incorporated into the capitation rates as a separate payment term to ensure clear monitoring of total payments made to the managed care plans and ultimately distributed to qualified providers through the directed payments.

This payment arrangement will be distributed quarterly to eligible providers in lump sum payments upon review of paid claims data for services provided on or after July 1, 2025. The State will work with the MCOs to monitor the amount paid out each quarter and make adjustments as needed to obtain the minimum 140% Medicare equivalent reimbursement level. These directed payment arrangements, in accordance with 42 CFR 438.6(c)(2)(ii)(F) are not renewed automatically.

7.4.1.7.1 Payments from the Contractor shall be completed within thirty (30) calendar days of the delivery of the reports and remittance of the lump sum payments from the Department.

7.4.1.7.2 Once the Contractor has issued the payment, the Contractor shall notify the Department by submitting a release of funds attestation signed by the Contractor's Chief Financial Officer or Chief Executive Officer on the Contractor's letterhead.

7.4.2 Rural Health Clinics (RHCs)

The Capitation Payment to the CONTRACTOR includes the units and expenditures applicable to the RHCs. The Department shall adjust Claims data to make RHC encounter payment levels equivalent to Medicaid FFS payment levels as specified in Section 1903(m)(2)(A)(ix) of the Act.

The CONTRACTOR shall:

7.4.2.1 Not make payment to a RHC that is less than the level and amount of payment that the CONTRACTOR makes for similar services to other Providers.

7.4.2.2 Not make payment to a RHC that is less than the level and amount of payment that the RHC would have been entitled to receive as reimbursement from the South Carolina Medicaid Program for a Medicaid FFS Claim. However, the CONTRACTOR may elect to make payment to the RHC at a level and amount that exceeds the Medicaid FFS reimbursement amount.

7.4.2.3 Submit the name of each RHC and detailed Medicaid Encounter data (i.e. Medicaid Recipient data, payment data, service/CPT codes) paid to each RHC by month of service to the Department for State Plan required reconciliation purposes. This information shall be submitted in the format required by the Department as contained in the Managed Care Report Companion Guide.

7.4.2.4 The Department is responsible for ensuring the supplemental payment determinations (wrap-around methodology) are calculated at least every three (3) months. The Department shall provide these reconciliations to the Rural Health Clinics on a quarterly basis.

7.4.3 Payment to Federally Qualified Health Centers (FQHCs)

The Capitation Payment to the CONTRACTOR includes the units and expenditures applicable to the FQHCs. The Department shall continue to utilize the Prospective Payment System (PPS) methodology for FQHC reimbursement as specified in Section 1903(m)(2)(A)(ix) of the Act.

The CONTRACTOR shall:

7.4.3.1 Not make payment to a FQHC that is less than the prospective payment amount that the FQHC would have been entitled to receive as reimbursement from the South Carolina Medicaid Program.

7.4.3.2 On a quarterly basis, submit the name of each FQHC and detailed Medicaid Encounter data of each FQHC by month of service to the Department for State Plan required reconciliation purposes. This information shall be submitted in the format required by the Department as contained in the Managed Care Report Companion Guide.

7.4.3.3 Reconcile all FQHC payments with the Prospective Payment system (PPS) amount.

7.4.3.3.1 Individual PPS rates shall be shared with the Contractor prior to the start of a new fiscal year. This document shall indicate all current encounter reimbursement rates that must be paid for the new fiscal year to eligible Providers.

7.4.3.4 Through their contractual relationship with FQHCs, determine when full payment is made for services rendered by the FQHC.

7.4.4 Payment to Indian Health Care Providers (IHCP)

The CONTRACTOR shall:

7.4.4.1 Ensure IHCPs which are enrolled in Medicaid as FQHC but are not participating providers of the Contractor must be paid an amount equal to the amount the Contractor would pay a FQHC that is a network provider but is not an IHCP to include any supplemental payment from the state to make up the difference between the amount the Contractor pays and what the IHCP FQHC would have received under Fee For Service (FFS). (42 CFR § 438.14(c)(1))

7.4.4.2 Ensure when an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the Contractor's network, it has the right to receive its applicable Encounter rate published annually in the Federal Register by the Indian Health Service (IHS) or the amount it would receive if the services were provided under the State Plan's FFS payment methodology, if the published Encounter rate is absent. (42 CFR § 438.14(c)(2))7.4.4.3 Ensure IHCPs, whether participating or not, be paid for covered services provided to Indian Members, who are eligible to receive services at a negotiated rate between the Contractor and IHCP or, in the absence of a negotiated rate, at a rate not less than the level and amount of payment the Contractor would make for the services to a participating Provider that is not an IHCP.

7.5 Cost Sharing/ Copayments

The CONTRACTOR shall not impose any Cost Sharing/Copayments on Members, regardless of service type or setting.

7.6 Premiums for Indian Members

The Contractor shall exempt from premiums any Indian Member who is eligible to receive or has received an item or service furnished by an IHCP or through referral under contract health services. (42 CFR 447.52(h); 42 CFR 447.56(a)(1)(x); ARRA 5006(a); 42 CFR 447.51(a)(2); SMDL 10-001)

7.7 Emergency Services

The CONTRACTOR shall pay Non-Contracted Providers for Emergency Services no more than the amount that would have been paid if the service had been provided under the State's FFS Medicaid Program. (SMDL 06-010; section 1932(b)(2)(D) of the Act)

7.7.1 Prior authorization for Emergency Services shall not be required of either Enrolled Providers or Non-Participating Providers (a.k.a. out-of-network Providers).

7.8 Payment Standards

Regardless of the payment methodology (i.e., Medicaid FFS or Capitated Payment) Medicaid cannot pay for services that are not medically necessary, as defined in this contract.

7.8.1 Medically Necessary Requirements

The CONTRACTOR must ensure that the payment and health care coverage Policies for network Providers include this requirement and have an approved definition of "Medically Necessary" in the CONTRACTOR's Provider manuals and handbooks, consistent with *Section 4* and Appendix A of this contract.

7.8.2 Health Records and Appropriate Documentation Requirements

The CONTRACTOR must also require that a Provider's Health Records or other appropriate documentation for each Member substantiate the need for services, include all findings and information supporting Medical Necessity and justification for services, and must detail all treatment provided.

7.8.3 CONTRACTOR Coding Standards and Billing Requirements

The CONTRACTOR shall:

7.8.3.1 Ensure, at a minimum, the CONTRACTOR's Policies and billing requirements for Providers follow CPT and HCPCS standards and guidelines where applicable.

7.8.3.2 Apply NCCI edits on a prepayment basis, in accordance with the approved State Plan and Department direction.

7.8.4 CONTRACTOR Policies and Federal and State Rules Requirements

The CONTRACTOR must follow all applicable federal and state rules in setting rates and policy for medical services and ensure that policy and coverage guidelines include restrictions

or prohibitions for specified services that cannot be paid for within the Medicaid Program. These include, but are not limited to:

7.8.4.1 Services that are cosmetic or experimental,

7.8.4.2 Other Non-Covered Services as specified in this contract.

7.8.5 CONTRACTOR Timely Claims Payment Requirements

Pursuant to 1932(f) and 1932(h) of the Social Security Act and 42 CFR § 447.45, the CONTRACTOR shall:

7.8.5.1 Pay ninety percent (90%) of all Clean Claims from Providers, including Indian Health Care Providers, within thirty (30) Calendar Days of the date of receipt; and

7.8.5.2 Pay ninety-nine percent (99%) of all Clean Claims from Providers, including Indian Health Care Providers, within ninety (90) Calendar Days of the date of receipt.

7.8.5.3 Establish an alternative payment schedule—a schedule that differs from the one specified above—under a mutual agreement.

7.8.5.4 Ensure that the date of receipt is the date it receives the Clean Claim, as indicated by its date stamp on the Claim; and that the date of payment is the date of the check or other form of payment.

7.8.6 Prohibition Against Lifetime Limits and Cumulative Financial Requirements

7.8.6.1 The Contractor shall not impose any aggregate lifetime limit or annual dollar limit for any medical/surgical benefits and mental health or substance use disorder benefits provided to Members through this contract in accordance with 42 CFR 438.905(e)(ii).

7.8.6.2 The Contractor shall not impose any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established medical/surgical benefits in the same classification in accordance with 42 CFR 438.910(c)(3).

7.9 Prohibited Payments

The CONTRACTOR shall not make payment for the following as required by Section 1903(i) of the Act, final sentence; section 1903(i)(2)(A) - (C) of the Act; section 1903(i)(16) - (17) of the Act:

7.9.1 Non-Emergency Items or Services

Non-Emergency items or services provided by, under the direction of, or under the prescription of an individual excluded from participation under Title V, XVIII, or XX or under Title 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act, or when the individual performing such item or service knew, or had reason to know, of the exclusion.

7.9.2 Assisted Suicide

Any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

7.9.3 Home Health

Any amount expended for home health care services unless the organization provides the appropriate surety bond as required under Section 1861(o)(7) of the Social Security Act.

7.9.4 Hospital-Acquired Condition (HAC) or Provider-Preventable Condition (PPC)

Any service resulting from a HAC or PPC that meets the following criteria:

7.9.4.1 Is identified in the State Plan,

7.9.4.2 Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of Procedures supported by evidence-based guidelines,

7.9.4.3 Has a negative consequence for the Member,

7.9.4.4 Is auditable,

7.9.4.5 Includes, at a minimum, wrong surgical or other invasive Procedure performed on a patient; surgical or other invasive Procedure performed on the wrong body part; surgical or other invasive Procedure performed on the wrong patient.

7.9.5 Individuals or Entities Pending Fraud Investigation

Non-Emergency items or service furnished by an individual or entity to whom the State, or the CONTRACTOR at the direction of the State, has failed to suspend payments during any period when there is a pending investigation of a Credible Allegation of Fraud against the individual or entity, unless the State determines there is good cause to not suspend such payments.

7.9.6 Other Non-State Plan Covered Services

Any amount expended for any other item or service not covered under the State Plan.

7.9.7 The Contractor shall make all payments in accordance with 42 CFR 438.60.

7.9.8 The Contractor shall ensure that its Contract with its pharmacy benefit manager (PBM) does not include language that permits any spread pricing arrangements or mechanisms that facilitate spread pricing including pharmacy provider reimbursement claw backs or discounts in its Contracts with pharmacy Providers.

7.10 Periodic and Annual Audits

7.10.1 The CONTRACTOR shall submit an annual audited financial report, in conformance with 42 CFR § 457.1201(k) and SC DOI regulation 69-70, by July 1st of each year. Detailed requirements for submission of the annual report are available in the Managed Care Report Companion Guide.

7.10.2 At least once during the initial term of this contract (July 1, 2024 through June 30, 2027) the CONTRACTOR shall submit to the Department pursuant to 42 CFR § 438.242(b)(3)(ii) an

independent audit of the accuracy, truthfulness, and completeness of the Encounter data and financial data submitted by, or on behalf of, the CONTRACTOR and in compliance with the requirements for Attestation Engagements, Examination Engagements, or Compliance Attestation as promulgated by the American Institute of Certified Public Accountants.. Detailed requirements for submission of this independent audit report are available in the Managed Care Report Companion Guide.

7.10.3. A separate annual independent audit report based on the contract year/state fiscal year must be submitted each year and shall conform with the requirements as stated in 42 CFR 438.3 (m). The independent audit report must be specific to the Medicaid Managed Care program and not include data related to other products or programs. The independent audit report must conform to Statutory Accounting Principles. Detailed requirements for submission of the Medicaid Managed Care specific annual independent audit report are available in the Managed Care Report Companion Guide.

7.10.4 In accordance with 42 CFR § 438.8 (k)(1)(xi) the CONTRACTOR shall submit a comparison of the information reported to the agency in conformance with 42 CFR § 438.8 Medical Loss Ratio (MLR) Standards with the audit report required above in compliance with 42 CFR § 438.3 (m) each year. Detailed requirements for submission of the comparison are available in the Managed Care Report Companion Guide.

7.10.5 When a CONTRACTOR finalizes the terms and conditions of a program that will pay funds to providers not related to specific claims the CONTRACTOR shall submit to the Department prior to its implementation, a program description of the initiative. If the program is governed by a contract, addendum, or amendment, a copy of the contract, addendum, or amendment, is also required.

7.11 Return of Funds

The CONTRACTOR shall:

7.11.1 Agree that all amounts identified as being owed to the Department are returned to the Department—no more than thirty (30) Days after notification to the CONTRACTOR by the Department—unless otherwise authorized in writing by the Department.

7.11.2 Accept and agree to the Department's right to collect amounts due by withholding future Capitation Payments.

7.11.3 Accept and agree to the Department's right to collect interest on unpaid balances beginning thirty (30) Calendar Days from the date of initial notification.

7.11.3.1 The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR § 30.13.

7.11.3.2 This rate may be revised quarterly by the Secretary of the Treasury and shall be published by the United States Department of Health and Human Services (HHS) in the Federal Register.

7.11.3.3 Ensure payment of funds being returned to the Department are submitted to:

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

7.12 Medicaid Provider Tax Returns

The CONTRACTOR shall:

7.12.1 Upon ninety (90) Days' notice from the Department, coordinate with the Department and the South Carolina Department of Revenue (SCDOR) for the collection of unpaid tax debts.

7.12.2 Be notified by the Department and/or SCDOR of delinquent tax debts owed by Subcontractors to the State of South Carolina. This notice will include a schedule of repayment.

7.12.3 Upon notice, Withhold/recoup funds from Subcontractors and transfer said funds to SCDOR in accordance with the notice.

7.12.4 Have responsibility for the authority to Withhold/recoup said funds from Subcontractors in accordance with this subsection of this contract.

Section 8. UTILIZATION MANAGEMENT

8.1 General Requirements

The CONTRACTOR shall develop and maintain Policies and Procedures with defined structures and processes for a utilization management (UM) program that incorporates utilization review and service authorization.

8.2 CONTRACTOR Utilization Management (UM) Program Requirements

The UM program description shall be exclusive to the South Carolina Medicaid Managed Care Program and shall not contain documentation from other state Medicaid Programs or product lines operated by the CONTRACTOR.

The CONTRACTOR shall:

8.2.1 At a minimum, establish Policies and Procedures consistent with 42 CFR § 456 and 42 CFR § 438.3(s). These Policies and Procedures must address the following provisions:

8.2.1.1 Process for monitoring over and under-utilization of services consistent with 42 CFR § 438.330(b)(3),

8.2.1.2 The methodology utilized to evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of physical and Behavioral Health Services,

8.2.1.3 Protocols for service authorization and denial of services; the process used to evaluate prior and concurrent authorization,

8.2.1.4 Documentation requirements regarding clinical review,

8.2.1.5 Mechanisms to ensure consistent application of review criteria and compatible decisions,

8.2.1.6 Data collection processes and analytical methods used in assessing utilization of physical and Behavioral Health Services,

8.2.1.7 Operate a drug utilization review program that complies with the requirements described in Section 1927(g) of the Act and 42 CFR § 456, subpart K, as if such requirement applied to the CONTRACTOR instead of the Department.

8.2.1.8 Provisions for assuring confidentiality of clinical and proprietary information,

8.2.1.9 Have written Procedures listing information required from a member or health care Provider to make Medical Necessity determinations. The CONTRACTOR shall make such Procedures available to a Medicaid Managed Care Member or Provider upon request,

8.2.1.10 Sufficient staff with clinical expertise and training to apply service authorization Medical Management criteria and practice guidelines. Refer to *Section 2* for additional details.

8.2.2 Use the Department's Medical Necessity definition for Medical Necessity determinations.

8.2.3 Ensure that only licensed individuals with appropriate clinical expertise address the Enrollee's medical, Behavioral Health, and/or long-term service and support needs and determine service authorization requests, denials, or authorize services in an amount, duration or scope that is less than requested.

8.2.4 Provide notice of Adverse Benefit Determinations. The CONTRACTOR's service authorization systems must notify the requesting Provider and give the Medicaid Managed Care Member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested in accordance with 42 CFR § 438.210(c). The Enrollee's notice must meet the requirements of § 438.404 and § 431.214.

8.2.5 Ensure that compensation to individuals or entities that conduct UM and SA activities is consistent with 42 CFR §§ 438.3(i), and 422.208 and not structured to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary Covered Services to any member in accordance with 42 CFR § 438.210(e).

8.3 CONTRACTOR Utilization Management (UM) Program Reporting Requirements

The CONTRACTOR shall:

8.3.1 Report Fraud and Abuse information identified through the UM program to the Department's Program Integrity (PI) Unit in accordance with the requirements established in *Section 11* of this contract.

8.3.2 In accordance with 42 CFR § 438.3(s)(5) provide the Department a detailed description of its drug utilization review program activities annually.

8.3.3 Provide to the Department, in the manner and format described in the Managed Care Report Companion Guide, quarterly reporting related to service authorization requests and denials.

8.4 Practice Guidelines

The CONTRACTOR shall:

8.4.1 Possess the expertise and resources to ensure the delivery of quality physical and Behavioral Health Services to Medicaid Managed Care Members in accordance with the Medicaid Program standards and the prevailing medical community standards.

8.4.2 Adopt practice guidelines in accordance with 42 CFR § 438.236(c). These guidelines must adhere to the following criteria:

8.4.2.1 Are based on valid and reliable clinical evidence or a consensus of physical and Behavioral Health care professionals in the particular field.

8.4.2.2 Consider the needs of the Medicaid Managed Care Members.

8.4.2.3 Are adopted in consultation with contracting physical and Behavioral Health Providers.

8.4.2.4 Are reviewed and updated periodically as appropriate.

8.4.3 Disseminate the guidelines to all affected Providers and, upon request, to Medicaid Managed Care Members and potential Medicaid Managed Care Members. Distribution methods may

include posting on the CONTRACTOR's website and provision of written materials upon request.

8.4.4 Ensure that decisions for utilization management, Medicaid Managed Care Member education, coverage of services and other areas to which guidelines apply are consistent.

8.4.5 Establish a process to encourage adoption of the guidelines.

8.5 Service Authorization

The CONTRACTOR shall:

8.5.1 Develop a service authorization process. Service authorization includes, but is not limited to, Prior Authorization and concurrent authorization and includes requests for the provision of Covered Services submitted by a Provider and includes request for the provision of service from a Medicaid Managed Care Member.

8.5.2 Develop Policies and Procedures for service authorization Procedures consistent with 42 CFR § 438.210 and state laws and regulations for initial and continuing authorization of services that include, but are not limited to, the following:

8.5.2.1 Written Policies and Procedures for processing requests for initial and continuing authorizations of services;

8.5.2.2 Mechanisms to ensure consistent application of review criteria for health service authorization decisions and consultation with the requesting Provider as appropriate;

8.5.2.3 Mechanisms to ensure that Prior Authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910(d);

8.5.2.4 Requirement that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a Health Care Professional who has appropriate clinical expertise in treating the Medicaid Managed Care Member's condition or disease;

8.5.2.5 Requirement that any authorization for managed long-term support services are based on the member's current needs assessment and is consistent with the member's person-centered service plan;

8.5.2.6 Provide the authorization number and effective dates for authorization to in-network Providers and applicable out-of- network Providers through the CONTRACTOR's service authorization system;

8.5.2.7 Have capacity to electronically store and report all service authorization requests, decisions made by the CONTRACTOR regarding the service requests, clinical data to support the decision, and time frames for notification of Providers and Members of decisions;

8.5.2.8 Provide notification of decisions to the requesting Provider and, in Cases of an adverse action, also provide written notification to the Member, in accordance with 42 CFR § 438.404;

And

8.5.2.9 Develop a mechanism within the CONTRACTOR's UM Policies and Procedures to provide for a preferred Provider program in which Provider's may obtain designation based on Quality. For purposes of this Section, such designation shall result in the Provider becoming eligible for a service authorization process that recognizes the Provider's ability to manage care including but not limited to exemption from service authorizations, expedited service authorization processes; service authorization processes based on simplified documentation standards.

8.5.3 Service Authorization Reporting by Benefit Type

The CONTRACTOR shall submit to the Department a complete and current list of all services that require service authorization, including prior authorization, concurrent authorization, or any other utilization management requirement applied before or during the delivery of a Covered Service. The list shall be submitted in accordance with the definitions, classifications, templates, and reporting instructions provided in the Managed Care Report Companion Guide. This reporting requirement supports the Department's oversight of compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA), including the application of non-quantitative treatment limitations (NQTLs). The list must:

8.5.3.1 Categorize each service into one of the following benefit classifications: Inpatient, Outpatient, Emergency Care, or Prescription Drugs.

8.5.3.2 Indicate whether each service is classified as a Mental Health or Substance Use Disorder (MH/SUD) benefit or a Medical/Surgical (M/S) benefit.

8.5.3.3 Specify the clinical criteria, guidelines, or evidentiary standards used to determine whether service authorization is required for each service.

8.5.3.4 Be submitted to the Department annually and within ten (10) business days of any material change to the CONTRACTOR's service authorization requirements.

8.6 Timeframe of Service Authorization Decisions

8.6.1 Standard Service Authorization

The CONTRACTOR shall:

8.6.1.1 Ensure responses to requests for service authorizations shall not exceed the time frames specified below as required by 42 CFR § 438.210(d)(2):

8.6.1.1.1 Provide notice as expeditiously as the Medicaid Managed Care Member's condition requires and within state- established time frames that may not exceed fourteen (14) Calendar Days following receipt of the request for service.

8.6.1.1.2 Elect to provide: (a) an extension for an additional fourteen (14) Calendar Days if the Medicaid Managed Care Member or the Provider or Authorized Representative requests an extension, or (b) if the CONTRACTOR justifies a need for additional information and the extension is in the member's best interest.

8.6.1.1.3 The CONTRACTOR shall make concurrent review determinations within seventy-two (72) hours of obtaining the appropriate medical information that may be required.

8.6.1.1.4 The CONTRACTOR shall give notice to the Provider and written notice to the member on the date that the timeframes expire when a service authorization decision has not been reached within the timeframe required.

8.6.1.2 Untimely service authorizations constitute a denial that the CONTRACTOR shall treat as an appealable adverse action.

8.6.2 Expedited Service Authorization

The CONTRACTOR:

8.6.2.1 Shall have a process for expedited service authorizations in accordance with 42 CFR § 438.210(d).

8.6.2.2 In the event a Provider indicates, or the CONTRACTOR determines, that following the standard service authorization timeframe could seriously jeopardize the Medicaid Managed Care Member's life, physical or Behavioral Health, or ability to attain, maintain, or regain maximum function, the CONTRACTOR shall make an expedited authorization decision and provide notice as expeditiously as the member's physical and/or Behavioral Health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

8.6.2.3 May elect to extend the seventy-two (72) hour time period by up to fourteen (14) Calendar Days if the Medicaid Managed Care Member requests an extension or if the CONTRACTOR justifies the need for additional information and how the extension is in the Medicaid Managed Care Member's best interest.

8.6.2.4 Shall give notice on the date that the timeframes expire when a service authorization decision has not been reached within the timeframe required.

8.6.2.5 Shall treat untimely service authorizations as a denial and an Adverse Action.

8.7 Exceptions to Service Authorization Requirements

8.7.1 Emergency Services and Post Stabilization Services

The CONTRACTOR shall:

8.7.1.1 Not require service authorization for Emergency Services or Post Stabilization Services as described in Section 4 of this contract.

8.7.2 Member Transitions

The CONTRACTOR shall:

8.7.2.1 Not require service authorization for the continuation of medically necessary Covered Services of a new Medicaid Managed Care Member transitioning into the CONTRACTOR's Health Plan in accordance with *Section 5* of this contract.

8.7.2.2 Not deny previously authorized services solely on the basis of the Provider being an out-of-network Provider during a new Medicaid Managed Care Member's transition period.

8.7.3 Women's Healthcare Services (Routine, Preventive and Pregnancy)

The CONTRACTOR shall

8.7.3.1 Not require a PCP referral (if the PCP is not a women's health specialist) for access to a women's health specialist contracted with the CONTRACTOR for routine and preventive women's healthcare services and prenatal care.

8.7.4 Opioid Treatment Program Clinic Services

8.7.4.1 Not require service authorization for Opioid Treatment Program Clinic Services.

8.8 Emergency Service Utilization

The CONTRACTOR shall:

8.8.1 Monitor emergency service utilization—by both Provider and Member— consistent with 42 CFR § 438.206.

8.8.2 Have guidelines for implementing corrective action for inappropriate utilization.

8.8.3 With respect to utilization review, use the test for appropriateness of the request for Emergency Services shall be whether a prudent layperson, similarly situated, would have requested such services. For the purposes of this contract, a prudent layperson is a person who possesses an average knowledge of health and medicine.

8.9 Out-of-Network Use of Non-Emergency Services

To the extent that the CONTRACTOR is unable to provide necessary medical services covered within the CONTRACTOR's network, the CONTRACTOR shall:

8.9.1 Provide timely coverage of these services out-of-network for the Medicaid Managed Care Member.

8.9.2 Require the out-of-network Providers to coordinate with respect to payment and must ensure that the cost to the Medicaid Managed Care Member is no greater than it would be if the covered Benefits and services were furnished within the CONTRACTOR's network.

8.9.3 Provide timely approval or denial of authorization of out-of-network use of Non-Emergency services through the assignment of a Prior Authorization number, which refers to and documents the approval.

8.9.4 Provide consistency with service approvals and/or denials.

8.9.5 Provide written or electronic documentation of the approval to the out-of- network Provider within one (1) Business Day.

Section 9. GRIEVANCE AND APPEAL PROCEDURES & PROVIDER DISPUTES

The CONTRACTOR shall establish and maintain a Grievance System and an appeal process for Adverse Benefit Determinations for Medicaid Managed Care Members and a separate Provider Dispute System.

The Grievance and Appeal System must comply with S.C. Code Ann. § 38-33-110, 42 CFR 438 Subpart F, and 42 CFR § 431 Subpart E. The Provider Dispute System must address Providers who are not satisfied with the CONTRACTOR's Policies and Procedures or a decision made by the CONTRACTOR.

The CONTRACTOR's Grievance and Appeal System Procedures and Provider Dispute System, and any changes thereto, must include, at a minimum, the requirements set forth herein. The CONTRACTOR shall refer all Members who are dissatisfied in any respect with the CONTRACTOR or its Subcontractor to the CONTRACTOR's designee authorized to review and respond to Grievances and Appeals.

9.1 Member Grievance and Appeal System

The CONTRACTOR must have a Grievance System in place for a Member that includes a Grievance process, an Appeal process that extends to the State's Fair Hearing system once the CONTRACTOR's Appeal process has been exhausted.

9.1.1 The Grievance System and process must address a "Grievance" and is defined in accordance with 42 C.F.R. § 438.400(b).

9.1.2 The Appeal system and process must address a request to review an Adverse Benefit Determination" filed on the behalf of the Member. An Adverse Benefit Determination is defined in accordance with 42 CFR § 438.400(b).

9.1.3 Access to the State's Fair Hearing system includes the following requirements:

9.1.3.1 The CONTRACTOR may only have one level of Appeal for their Medicaid Managed Care Members.

9.1.3.2 Members must exhaust the CONTRACTOR's Appeal process prior to filing for a State Fair Hearing. If the CONTRACTOR fails to adhere to the notice and timing requirements in 42 CFR 438.408(a)(2), the Member is deemed to have exhausted the CONTRACTOR's Appeals process. The Member may then initiate a State Fair Hearing.

9.1.3.3 The Contractor must inform Medicaid Managed Care Members how to seek a State Fair Hearing if the Member is not satisfied with the CONTRACTOR's decision in response to an Appeal. (See 42 CFR 438.408)

9.2 Filing Requirements

The CONTRACTOR must allow Members and Authorized Representatives, acting on behalf of the Member and with the Member's written consent, to file Grievances, Appeals, or state fair hearings (42 CFR § 438.402(c)(1)(ii).

The following requirements apply to the filing of Grievances or Appeals:

9.2.1 Authority to File

9.2.1.1 A Member may file a Grievance and a CONTRACTOR level Appeal and may request a State Fair Hearing once the CONTRACTOR's Appeals process has been exhausted.

9.2.1.2 As state law permits and with written consent of the Member, an Authorized Representative may request an Appeal or file a Grievance, or request a State Fair Hearing, on behalf of a Member, with the exception that Providers cannot request continuation of Benefits as specified in §438.420(b)(5).

9.2.2 The CONTRACTOR shall adhere to the following timeframes for filing of Grievances and Appeals:

9.2.2.1 A Grievance may be filed with the CONTRACTOR at any time.

9.2.2.2 Following receipt of a notification of an Adverse Benefit Determination by the CONTRACTOR, a Member has 30 Calendar Days from the date on the Adverse Benefit Determination notice in which to file a request for an Appeal to the Contractor.

9.2.3 Filing Procedures

9.2.3.1 The Member, or the Member's Authorized Representative may file a Grievance or Appeal with the CONTRACTOR either orally or in writing.

9.3 Notice of Grievance and Appeals Procedures

The CONTRACTOR shall ensure that all its Members are informed of the State's Fair Hearing process and of the CONTRACTOR's Grievance and Appeal Procedures. The CONTRACTOR's Medicaid Managed Care Member handbook shall include descriptions of the CONTRACTOR's Grievance and Appeal Procedures. Forms on which Members may file Grievances, Appeals, concerns or recommendations to the CONTRACTOR shall be available through the CONTRACTOR,'s website and must be provided upon the request.

9.3.1 Grievance/Appeal Records and Reports

9.3.1.1 A copy of an oral Grievances log and records of any Appeals, including Appeals filed directly with the Contractor and the State's Fair Hearing system, shall be retained in accordance with the provisions of S.C. Code Ann. § 38-33-110 (A)(2) and made available to the Department upon request or as required by this contract.

9.3.1.1.1 The CONTRACTOR shall provide the Department with a quarterly and annual Grievance and Appeal report that contains at a minimum, those requirements as stated in 42 CFR 438.416(b) and as described in the Managed Care Report Companion Guide.

9.3.1.1.2 All Appeal and Grievance records shall be accurately maintained in a manner accessible to the Department and available upon request to CMS.

9.3.1.1.3 The Contractor shall maintain a separate spreadsheet for oral Grievances and Appeals, written Grievances and Appeals, and records of disposition.

9.4 Handling of Grievances and Appeals

Pursuant to 42 CFR § 438.406, the Procedures for Grievances and Appeals shall be governed by the following requirements. The Contractor shall:

9.4.1 Provide Members any assistance in completing forms and taking other procedural steps. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/ TTD and interpreter capability.

9.4.2 Ensure that the individuals who make decisions on Grievances and Appeals are individuals:

9.4.2.1 Who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual,

9.4.2.2 Who, if deciding: (1) an Appeal of a denial based on lack of Medical Necessity; (2) a Grievance regarding denial of expedited resolution of an Appeal; or (3) a Grievance or Appeal that involves clinical issues, are Health Care Professionals who have the appropriate clinical expertise, as determined by the State, in treating the Member's condition or disease.

9.4.2.3 Who consider all comments, documents, records, and other information submitted by the Member or their Representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

9.4.3 Ensure the process for Appeals shall:

9.4.3.1 Allow oral inquiries seeking to Appeal an Adverse Benefit Determination are treated the same as Appeal requests in writing (to establish the earliest possible filing date for the Appeal). The timeline for the Appeal begins with the receipt of the Member's initial notification of their request for an Appeal (oral or written) to the CONTRACTOR.

9.4.3.2 Provide the Member or the Member's Authorized Representative a reasonable opportunity to present evidence and testimony and make legal and factual arguments, and allegations of fact, policy, or law, in person as well as in writing. The CONTRACTOR shall inform the Member of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals as specified in §438.408(b) and (c) in the case of expedited resolution.

9.4.3.3 Provide the Member or their Authorized Representative the Member's file, including, but not limited to, Health Records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the CONTRACTOR (or at the direction of the CONTRACTOR) in connection with the Appeal of the Adverse Benefit Determination. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for Appeals as specified in §438.408(b) and (c).

9.4.4 Includes, as parties to the Appeal, (1) The Member and his or her Authorized Representative, Or (2) The Legal Representative of a deceased Member's estate.

9.4.5 Ensure the CONTRACTOR's staff is educated concerning the importance of the Grievance and Appeal Procedures and the rights of the Members and Providers.

9.4.6 Ensure the appropriate individual or body within the CONTRACTOR's Health Plan that possesses decision-making authority is identified as part of the Grievance/Appeal Procedure.

9.4.7 Attempt to resolve Grievances through internal mechanisms whenever possible and to contact the Member by letter or telephone providing them with the Contractor's resolution.

9.5 Notice of Adverse Benefit Determination

9.5.1 Language and Format Requirements

9.5.1.1 The CONTRACTOR shall give the Member timely and adequate written notice of an Adverse Benefit Determination within the timeframes for each type of Adverse Benefit Determination.

9.5.1.2 The Contractor shall ensure the Notice of Adverse Benefit Determination is in writing and meets the language and format requirements as set forth in *Section 12* of this contract and in accordance with 42 CFR § 438.10.

9.5.2 Content of Notice of Adverse Benefit Determination

The Notice of Adverse Benefit Determination must include specific information about the action. This information must explain, at a minimum, the following:

9.5.2.1 The Adverse Benefit Determination the CONTRACTOR or its Subcontractor has taken or intends to take;

9.5.2.2 The basis for the Adverse Benefit Determination;

9.5.2.3 The Member's right to file an Appeal with the CONTRACTOR;

9.5.2.4 The Member's right to request a State Fair Hearing, after the CONTRACTOR's Appeal process has been exhausted;

9.5.2.5 The Procedures for exercising the rights specified in this Section of this contract;

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

9.5.2.7 The Member's right to have Benefits continue pending resolution of the Appeal; how to request that Benefits be continued; and the circumstances under which the Member may be required to pay the costs of these services.

9.5.3 Timing of Notice of Adverse Benefit Determination

The CONTRACTOR shall mail the notice within the following timeframes:

9.5.3.1 For termination, suspension, or reduction of previously authorized Covered Services: at least ten (10) Calendar Days before the date the Adverse Benefit Determination takes effect, except as permitted under 42 CFR §§ 431.211, 431.213 and 431.214.

9.5.3.2 For denial of payment: at the time of any Adverse Benefit Determination.

9.5.3.3 For standard service authorization decisions that deny or limit services: as expeditiously as the Member's health condition requires, but not to exceed fourteen (14) Calendar Days following receipt of the request for service, with a possible extension of up to fourteen (14) additional Calendar Days, if:

9.5.3.3.1 The Member, or the Member's Authorized Representative, requests extension, or

9.5.3.3.2 The CONTRACTOR justifies (to the Department upon request) a need for additional information and how the extension is in the Member's best interest.

9.5.3.4 If the CONTRACTOR extends the timeframe if it meets the criteria set forth for in this contract and is consistent with 42 CFR §438.210(d)(1)(ii), the Contractor shall:

9.5.3.4.1 Provide the Member written notice of the reason for the decision to extend the timeframe and inform the Member of their right to file an Appeal if he or she disagrees with that decision, and,

9.5.3.4.2 Issue and carry out its determination as expeditiously as the Member's health condition requires, but no later than the date the extension expires.

9.5.3.5 For service authorization decisions not reached within the timeframes specified: (which constitutes a denial and is thus an Adverse Benefit Determination), on the date that the timeframes expire.

9.5.3.6 For expedited service authorization decisions where a Provider indicates, or the CONTRACTOR determines, that following the standard timeframe could seriously jeopardize the Member's life or ability to attain, maintain, or regain maximum function, the CONTRACTOR shall make a decision and provide notice as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after receipt of the request for service.

9.5.3.6.1 The CONTRACTOR may extend the seventy- two (72) hour time period up to fourteen (14) Calendar Days if the Member requests an extension, or if the CONTRACTOR justifies (to the Department upon request) a need for additional information and how the extension is in the Member's best interest.

9.5.3.7 The Department shall conduct periodic random audits to ensure that Members are mailed such notices as outlined in this section.

9.6 Resolution and Notification

The CONTRACTOR shall resolve Grievances and Appeals, and provide notice as expeditiously as the Member's health condition requires, but also within the timeframes established herein:

9.6.1 Specific Timeframes

9.6.1.1 Standard Resolution of Grievances

For standard resolution of a Grievance and notice to the affected parties, the timeframe shall not exceed ninety (90) Calendar Days from the day the CONTRACTOR receives the Grievance.

9.6.1.2 Standard Resolution of Appeals

For standard resolution of an Appeal and notice to the affected parties, the timeframe shall not exceed thirty (30) Calendar Days from the day the CONTRACTOR receives the Appeal. This timeframe may be extended under the Extension of Timeframes provisions Section of this contract.

9.6.1.3 Expedited Resolution of Appeals

For expedited resolution of an Appeal and notice to affected parties, the timeframe shall not exceed seventy- two (72) hours after the CONTRACTOR receives the Appeal. This timeframe may be extended under the Extension of Timeframes provisions Section of this contract.

9.6.1.4 Extension of Timeframes

The CONTRACTOR may extend the timeframes stated in this subsection of this contract by up to fourteen (14) Calendar Days if:

9.6.1.4.1 The Member requests the extension, or

9.6.1.4.2 The CONTRACTOR shows (to the Department's satisfaction, upon its request) that there is need for additional information and how the delay is in the Member's best interest.

9.6.1.5 Requirements Following Extension

9.1.6.1.5.1 Make reasonable efforts to give the Member prompt oral notice of the delay.

9.1.6.1.5.2 Within two (2) Calendar Days give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision.

9.1.6.1.5.3 Resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

9.6.2 Format of Notice of Resolution

9.6.2.1 The resolution of a Grievance shall meet the standards described at 42 CFR §438.10. Disposition of a written Grievance shall be communicated to the Member with written correspondence delivered first class, utilizing the United States Postal System (USPS). Grievances submitted orally may be responded to either orally or in writing unless the Member requests a written response.

9.6.2.2 For all Appeals, the CONTRACTOR must provide written notice of resolution. For notice of an expedited resolution, the CONTRACTOR must also make reasonable efforts to provide prompt oral notice.

9.6.2.3 The written notice of the resolution shall include, at a minimum, the following:

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

9.6.2.3.2 For Appeals not resolved wholly in favor of the Members:

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

9.6.2.3.2.2 The right to request to continue to receive Benefits while the State Fair Hearing process is pending, and how to make the request; and

9.6.2.3.2.3 An explanation that the Member may be held liable for the cost of those Benefits if the State Fair Hearing decision upholds the CONTRACTOR's Adverse Benefit Determination.

9.6.3 Procedures Related to State Fair Hearings

9.6.3.1 If a Member has exhausted the CONTRACTOR’s Appeal process, the Member may request a State Fair Hearing no later than one-hundred and twenty (120) Calendar Days from the date of the CONTRACTOR’s notice of resolution. The CONTRACTOR shall send the CONTRACTOR’s notice of resolution to the Member via certified mail, return receipt requested.

9.6.3.1.1 The Contractor shall ensure that the denial notice is delivered to the Member’s current address. If the mail was unable to be delivered (letter was refused, or address was invalid), the one-hundred and twenty (120) calendar-day time period will begin upon the final attempt to deliver the denial notice.

9.6.3.2 If the CONTRACTOR fails to adhere to the notice and timing requirements described in this Section, the Member shall be deemed to have exhausted the CONTRACTOR’s Appeals process. The Member may then initiate a State Fair Hearing.

9.6.3.3 The Department’s standard timeframe for reaching an expediated State Fair Hearing decision shall be within ninety (90) Calendar Days from the date the Member filed the Appeal with the Contractor, excluding any Days it takes the Member to file the request for State Fair Hearing.

9.6.3.4 The parties to the State Fair Hearing include the CONTRACTOR as well as the Member and/or his or her Authorized Representative or an individual with the legal authority to act on the Member’s behalf.

9.6.3.5 In the event a Member or Authorized Representative that the Member chooses to act on their behalf (including a Provider), requests a State Fair Hearing, the Contractor shall transmit copies of all communication (written and electronic) to the Contractor's

Department Contract Monitor concurrent with communication to the Member, the Authorized Representative, and the Department's hearing officer.

9.6.4 Expedited Resolution of Appeals

The CONTRACTOR shall establish and maintain an expedited review process for Appeals, wherein the CONTRACTOR determines, in response to a request from the Member or the Authorized Representative, that taking the time for a standard resolution could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

9.6.4.1 The CONTRACTOR shall ensure that punitive action is not taken against a Provider who requests an expedited resolution while acting as an Authorized Representative for the Member or provides support during a Member's Appeal.

9.6.4.2 If the CONTRACTOR denies a request for expedited resolution of an Appeal, the Contractor shall:

9.6.4.2.1 Transfer the Appeal to the timeframe for standard resolution in accordance with 42 CFR 438.408(b)(2); and

9.6.4.2.2 As required in 42 CFR 438.410, make reasonable efforts to provide the Member prompt oral notice of the denial.

9.6.4.2.2.1 Follow up for the denial shall be provided within two (2) Calendar Days with a written notice for the decision to deny an expedited resolution of the Appeal.

9.6.4.2.2.2 The CONTRACTOR shall resolve the Appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

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

9.6.4.4 To avoid delays in the expedited State Fair Hearing review process, the Contractor shall communicate to the Member or their Authorized Representative acting on their behalf any supporting documentation that should be submitted with the request for expedited review, or immediately thereafter. While supporting documentation is not required, the Department shall make its determination based on the information made available at the time the request is considered.

9.7 Continuation of Benefits while the CONTRACTOR-Level Appeal and the State Fair Hearing are Pending

9.7.1 For purposes of this Section of the contract, "timely" filing means filing on or before the later of the following:

9.7.1.1 Within ten (10) Calendar Days of the CONTRACTOR mailing the notice of Adverse Benefit Determination.

9.7.1.2 The intended effective date of the CONTRACTOR's proposed Adverse Benefit Determination.

9.7.2 The CONTRACTOR shall continue the Member's Benefits if all the following occur:

9.7.2.1 The Member files the Appeal timely in accordance with §438.402(c)(1)(ii) and (c)(2)(ii);

9.7.2.2 The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

9.7.2.3 The services were ordered by an authorized Provider;

9.7.2.4 The original period covered by the original authorization has not expired; and

9.7.2.5 The Member or his or her Authorized Representative requests timely extension of Benefits.

9.7.3 If, at the Member's request, the CONTRACTOR continues or reinstates the Member's Benefits while the Appeal or State Fair Hearing is pending, the Benefits must be continued until one of following occurs:

9.7.3.1 The Member withdraws the Appeal or State Fair Hearing.

9.7.3.2 The Member fails to request a State Fair Hearing and continuation of Benefits within ten (10) Calendar Days after the CONTRACTOR sends the notice of an adverse resolution to the Member’s Appeal under 42 CFR §438.408(d)(2)

9.7.3.3 A State Fair Hearing officer issues a hearing decision adverse to the Member.

9.7.4 If the final resolution of the Appeal is adverse to the Member (i.e., the CONTRACTOR's Adverse Benefit Determination is upheld), the CONTRACTOR may recover the cost of the services furnished to the Member while the Appeal was pending, to the extent that the services were furnished solely because of the requirements of this Section and in accordance with the requirements set forth in 42 CFR § 431.230(b) as specified in 42 CFR § 438.420(d).

9.7.5 The CONTRACTOR shall not submit any Encounter information related to the services appealed if it recoups the money from the Member.

9.8 Effectuation of Reversed Appeal Resolutions

9.8.1 Services Not Furnished While Appeal is Pending

If the CONTRACTOR or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the CONTRACTOR shall authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires but no later than seventy-two (72) hours from the date the CONTRACTOR receives notice reversing the Adverse Benefit Determination.

9.8.2 Services Furnished While Appeal is Pending

If the CONTRACTOR or the State Fair Hearing officer reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal was pending, the CONTRACTOR shall pay for those services, in accordance with state policy and regulations.

9.9 Grievance System Information to Providers and Subcontractors

The CONTRACTOR shall provide the information specified in 42 CFR § 438.10(g)(2)(xi) in a Department-approved format about the Grievance System to all Providers and Subcontractor's at the time they enter into a contract with the CONTRACTOR as follows:

9.9.1 The Member's right to file a Grievance and/or Appeal, the requirements for filing, and timeframe for filing;

9.9.2 Availability of assistance with filing Grievances and Appeals;

9.9.3 The toll-free number to file oral Grievances and Appeals;

9.9.4 The Member's right to request continuation of Benefits during an Appeal or State Fair Hearing filing, and information that addresses that the Member may be liable for the cost of any continued Benefits if the Adverse Benefit Determination is upheld, and;

9.9.5 Any CONTRACTOR-determined Provider rights to challenge the failure of the CONTRACTOR to cover a service.

9.10 Provider Dispute System

The CONTRACTOR shall establish an internal Provider Dispute System for Providers, not otherwise acting in the capacity of an Authorized Representative of a Member, described under this Section of the contract. This Provider Dispute System shall be utilized as the sole remedy to dispute the denial of payment of a Claim or, in the case of a contracted, in-network Provider, to dispute the CONTRACTOR's Policies, Procedures, rates, Contract Disputes or any aspect of the CONTRACTOR's administrative functions. Providers not otherwise acting in the capacity of an Authorized Representative of a Member do not have Appeal rights with the Department. At a minimum, the Provider Dispute System shall:

9.10.1 Have dedicated Provider relations staff for Providers to contact via telephone, electronic mail, surface mail, and in person, to ask questions, file a Provider Dispute and resolve problems.

9.10.2 Identify a staff person specifically designated to receive and process Provider Disputes.

9.10.3 For contracted in-network Providers, address any adverse action, including the denial or reduction of Claims for services included on a Clean Claim.

9.10.4 For Non-Contracted out-of-network Providers, address nonpayment, denial or reduction of a Covered Service rendered out of network, including emergency care.

9.10.5 The CONTRACTOR's Provider Dispute System does not have to address CONTRACTOR's decision to not contract with a Provider, CONTRACTOR's decision to terminate a contract

with a Provider, denials due to payment adjustments for National Correct Coding Initiative (NCCI), or services that are not covered under this contract.

9.10.6 Establish a process to thoroughly investigate each Provider Dispute using applicable statutory, regulatory, contractual and Provider Subcontract provisions, collecting all pertinent facts from all parties and applying the CONTRACTOR's written Policies and Procedures.

9.10.7 Ensure that individuals with the authority to require corrective action are involved in the Provider Dispute System.

9.10.8 Implement written Policies and Procedures that detail the operation of the Provider Dispute System and submit its Provider Dispute System Policies and Procedures to the Department annually. The Policies and Procedures shall include, at a minimum:

9.10.8.1 Providers shall be allowed thirty (30) Calendar Days from the receipt of notice of an Adverse Action to file a written Dispute,

9.10.8.2 A description of how a Provider may file a Dispute with the CONTRACTOR for issues that are to be addressed by the Provider Dispute System, and

9.10.8.3 A description of how the CONTRACTOR's Provider Relations Staff are trained to distinguish between a Provider Dispute and a Member Grievance or Appeal in which the Provider is acting on the Member's behalf.

9.10.9 For Disputes related to denial of payment or reduction in payment, the CONTRACTOR shall allow Providers to consolidate Disputes of multiple Claims that involve the same or similar payment issues, regardless of the number of individual patients or payment Claims included in the bundled complaint.

9.10.10 The CONTRACTOR shall investigate and render a written decision regarding Disputes within thirty (30) Calendar Days of the request of the Provider Dispute. The CONTRACTOR's review shall consist of an administrative review conducted by a supervisor and/or manager employed by the CONTRACTOR with the authority to revise the initial Claims determination if needed. The decision, if denied, must include a description of the Provider's next step if the issue remains unresolved.

9.10.11 For Disputes involving Medical Necessity, or a clinical issue, the CONTRACTOR shall ensure that decision-makers are Health Care Professionals with appropriate clinical expertise.

9.10.12 To the extent additional information is required to render a decision on the Dispute, the CONTRACTOR may extend the timeframe by fifteen (15) calendar Days based on mutual agreement of the Provider and the CONTRACTOR.

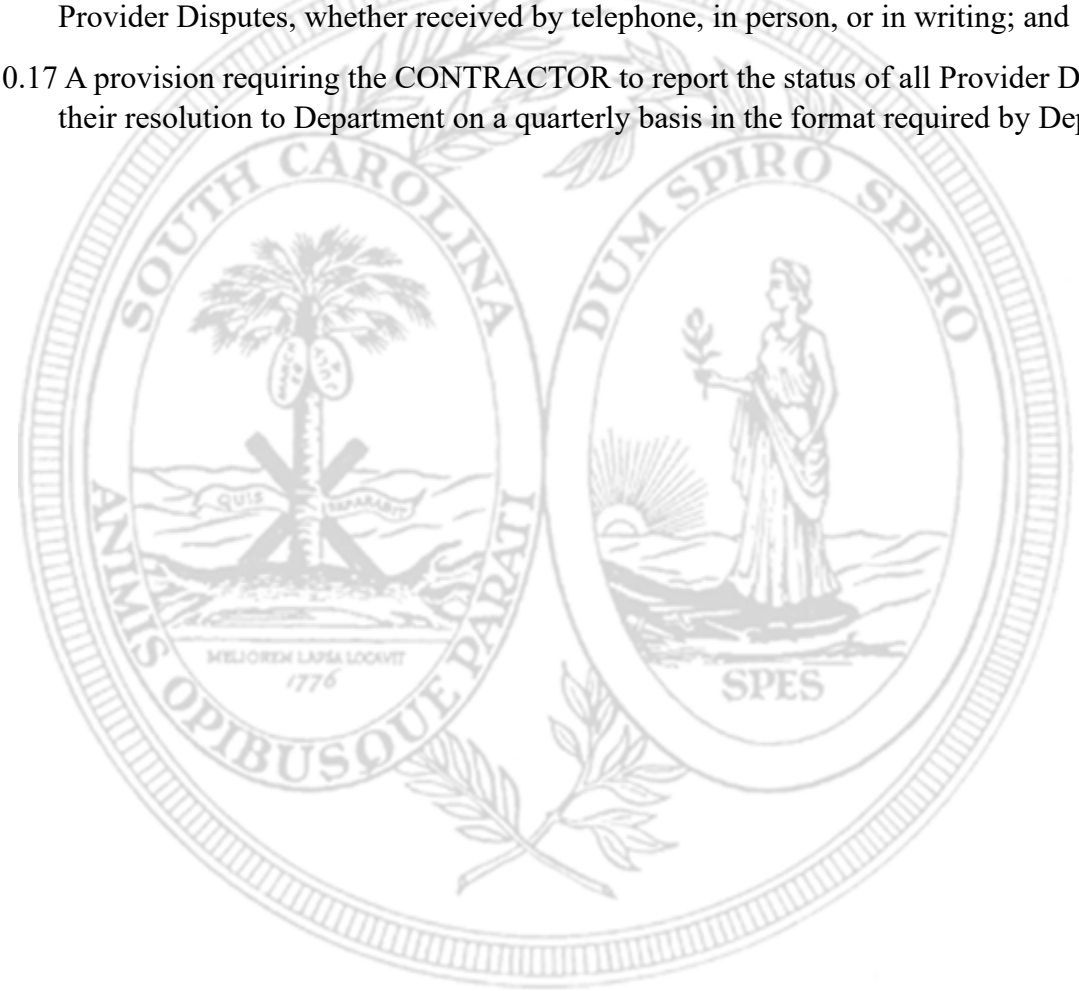
9.10.13 A description of the methods used to ensure that the CONTRACTOR's executive staff who possess the authority to require corrective action are involved in the Dispute System process(es), as necessary.

9.10.14 A process for giving Providers (or their Representatives) the opportunity to present their Dispute(s) in person.

9.10.15 Identification of specific individuals who have authority to administer the Provider Dispute process.

9.10.16 Possess capabilities to capture, track, and report the status and resolution of all Provider Disputes, including all associated documentation. This system must capture and track all Provider Disputes, whether received by telephone, in person, or in writing; and

9.10.17 A provision requiring the CONTRACTOR to report the status of all Provider Disputes and their resolution to Department on a quarterly basis in the format required by Department.



Section 10. THIRD PARTY LIABILITY

10.1 General

Medicaid is the payer of last resort and pays for Covered Services only after any other sources have paid. Federal law requires South Carolina to have in place processes and Procedures to identify Third Parties liable for payment of services under the South Carolina State Plan for Medical Assistance and for payment of Claims involving Third Parties. See S.C. Code Ann. § 43-7-410 et seq (Supp. 2011, as amended) for definitions and statutory requirements.

Federal law considers the program outlined in the South Carolina statute and the federal regulations to be the Third-Party Liability (TPL) Program. This involves identification of other payers, including, but not limited to, group health and other health insurers, Medicare, liability insurance and workers' compensation insurance.

In accordance with federal law, South Carolina state law considers all Medicaid Members, including Medicaid Managed Care Members, to have assigned to the Department their rights to payment or recovery from a Third Party or private insurer. State law also requires that Medicaid Members cooperate with the Department in the enforcement of these assigned rights. Failure to cooperate with the Department violates the conditions for eligibility and may result in the Member's loss of Medicaid eligibility. South Carolina law also subrogates the Department to the Medicaid Member's right to recover from a Third Party.

10.2 Department Responsibilities

The Department shall be responsible for maintaining the contract(s) needed for insurance verification services or to identify Third Party coverage for all Members, regardless of the health care service delivery system.

10.2.1 The Department shall provide data to the CONTRACTOR regarding any third- party insurance coverage for any covered Member in the CONTRACTOR's Health Plan.

10.2.2 While the Department shall make reasonable efforts to ensure accuracy of shared data, the Department cannot guarantee the accuracy of the data.

10.2.2.1 Member's policy additions and updates to a Member's policy record shall be passed to the Contractor at least monthly.

10.2.2.2 Only verified TPL coverage data shall be passed to the Contractor.

10.3 CONTRACTOR Responsibilities

The CONTRACTOR shall administer the TPL Program requirements in accordance with Section 1902(a)(25) of the Social Security Act, 42 CFR § 433 Subpart D and 42 CFR § 447.20, as they apply to services provided under this contract to Medicaid Managed Care Members.

The CONTRACTOR Shall:

10.3.1 Coordinate Benefits in accordance with 42 CFR § 433.135 and Department requirements as outlined in this contract.

10.3.2 Implement cost avoidance and post-payment recovery Procedures in accordance with federal and state requirements.

10.3.3 Take reasonable measures to identify any legally liable Third Party insurance coverage for its Members; this shall include both health insurance coverage (including government payers such as Medicare and TriCare) and casualty insurance coverage.

10.3.3.1 If, after the CONTRACTOR makes all reasonable efforts to obtain Member cooperation, a Member refuses to cooperate with the CONTRACTOR in pursuit of liable Third Parties, the CONTRACTOR will consult with the Department.

10.3.4 Adjudicate the Claim and use post-payment recovery if the probable existence of Third Party Liability was not established by either the CONTRACTOR or the Department prior to submission of the Claim.

10.3.5 Pass to the Department any newly identified Member insurance that the Department does not have on file for that Member, each month by the 5th of the month. The Contractor shall use the format requested by the Department.

10.3.5.1 The Contractor shall ensure the completeness and accuracy of the policy information submitted, to include carrier code and policy numbers.

10.3.6 Regardless of a primary insurers timely filing period, the Contractor shall not recover payments from the Provider after the Provider's timely filing limit has been exhausted.

10.4 Cost Avoidance

The CONTRACTOR shall have processes, methods, and resources necessary to receive TPL data from the Department and to identify third-party coverage for its Members; this information will be used in managing Provider payment at the front end before the Claim is paid. Medicaid is required to reject claims for which another party might be liable; this policy is known as cost avoidance. The Contractor must require Providers to report primary payments and denials.

10.4.1 The CONTRACTOR shall have appropriate edits in the Claims system to ensure that Claims are properly coordinated when other insurance is identified.

10.4.1.1 The CONTRACTOR's Medicaid reimbursement and Third Party payment cannot exceed the amount the Provider has agreed to accept as payment in full.

10.4.2 If the probable existence of TPL has been established at the time the Claim is filed, the CONTRACTOR shall reject the Claim and return it to the Provider for a determination of the amount of any TPL.

10.4.3 The Contractor shall require Providers (both contracted and non-contracted) to ascertain whether a Member has existing TPL coverage at the point of service.

10.4.4 For certain services, the CONTRACTOR should not cost-avoid Claims and will pursue recovery under a policy known as "Pay & Chase". While Providers of such services are encouraged to file with any liable Third Party before the CONTRACTOR, if they choose not to

do so, the CONTRACTOR shall pay the Claims and bill liable Third Parties directly through a Benefit Recovery Program for services defined as pay and chase services.

10.4.4.1 The only exclusions to cost avoidance are those services designated as pay and chase services listed below:

10.4.4.1.1 School Based Services covered under a Medicaid-eligible child's IEP/IFSP;

10.4.4.1.1.1 Medicaid is the primary payor for IDEA-related services;

10.4.4.1.2 Preventive pediatric services;

10.4.4.1.3 Dental EPSDT services;

10.4.4.1.4 Title IV – Child Support Enforcement insurance records;

10.4.4.1.5 After one hundred (100) days, certain Department of Public Health (DPH) services under Title V.

10.4.4.2 While providers of such services are encouraged to file with any liable third party before Medicaid, if they choose not to do so, the Department shall pay the claims and bill liable third parties directly through the Benefit Recovery program.

10.4.4.3 If the Contractor chooses to bill both a third party and Medicaid, the Contractor shall enter the TPL filing information on the Medicaid claim.

10.4.4.3.1 Rendering Pay & Chase eligible services does not exempt the Contractor from the requirement to correctly code for TPL.

10.4.5 When a Claim is denied because a Member has not satisfied a Third-Party deductible and/or copay requirement, then the Claim should be processed by the Contractor according to its usual Procedures.

10.4.6 The CONTRACTOR shall deny payment on a Claim that has been denied by a known Third Party payer, as defined in this Section of the contract, so long as the reason for the denial of payment is in accordance with Section 43-7-465 of the S.C. Code. The Contractor shall not deny a payment for an item or service rendered to a Member on the basis that the item or service did not receive prior authorization for the third-party payor.

10.5 Post-Payment Recovery

Post-payment recovery is necessary in cases where the CONTRACTOR has not established the probable existence of a liable Third Party at the time services were rendered or paid for, for Members who become retroactively eligible for Medicare, or in situations when the CONTRACTOR was unable to cost-avoid.

10.5.1 The CONTRACTOR shall have Procedures in place to ensure that a Provider who has been paid by the CONTRACTOR and subsequently receives reimbursement from a Third Party repays the CONTRACTOR either the full amount paid by Medicaid or the full amount paid by the Third Party, whichever is less.

10.5.2 CONTRACTOR Post-Payment Recovery Requirements

The CONTRACTOR shall have established Procedures for recouping post-payment.

10.5.2.1 The Procedures shall be made available for review upon request by the Department.

10.5.2.2 The CONTRACTOR shall void Encounters for Claims that are recouped in full.

10.5.2.3 The CONTRACTOR shall submit a replacement Encounter for Recoupments that result in an adjusted Claim value.

10.5.2.4 The CONTRACTOR shall seek reimbursement in accident/trauma-related cases when Claims in the aggregate equal or exceed $250.

10.5.2.5 The CONTRACTOR shall report all recoveries it collects outside of the Claims processing system, including settlements.

10.5.2.5.1 The CONTRACTOR shall treat such recoveries as offsets to medical expenses for the purposes of reporting.

10.5.2.6 The Contractor shall use an established monthly billing cycle to recover expenditures for Claims which should be covered by other Third-Party Resources without regard to dollar amount. At the end of each month, the Contractor Claims database shall search for Claims which should have been covered by Policies added during the previous month and for Claims which were not cost avoided.

10.5.2.7 Upon request by the Department, the Contractor shall demonstrate that reasonable effort has been made to seek, collect and/or report Third Party recoveries. The Department shall have the sole responsibility for determining whether reasonable efforts have been demonstrated by the Contractor.

10.5.2.8 The CONTRACTOR shall bill or inform the Provider to bill the third-party coverage within thirty (30) Days of identification of TPL.

10.5.3 Refund Request Letter

The Contractor shall send letters to Providers or insurance companies requesting reimbursement of Contractor payments for Claims involving primary health insurance. Follow-up letters are automatically generated if refunds have not been made within ninety (90) calendar days.

10.5.3.1 Prior to Recoupment of its payment, the Contractor shall notify the Provider with a Refund Request Letter that includes, at a minimum:

10.5.3.1.1 The name of the Contractor;

10.5.3.1.2 The name of the Provider;

10.5.3.1.3 The list of Claims or a reference to a remit advice date;

10.5.3.1.4 Member name;

10.5.3.1.5 The reason the Contractor considers the payment was made in error (commercial insurance responsible);

10.5.3.1.6 The identification and contact information of the primary insurance carrier at the time of service;

10.5.3.1.7 A time period of at least forty-five (45) calendar Days in which the Provider may reimburse the Contractor's payment and /or Dispute the decision;

10.5.3.1.8 Information on how to file a Provider Dispute, and;

10.5.3.1.9 A request that the Provider submit Claims to the commercial insurance carrier or Medicare if not already done.

10.5.3.2 When Providers choose to dispute the refund request letter from the Contractor, the Provider shall be given thirty (30) calendar days in addition to the forty-five (45) initial calendar days stated in the letter to provide sufficient documentation to the Contractor prior to the Contractor's recovery of their payment.

10.5.3.2.1 Providers should include in their dispute a copy of a denial from the Member's primary carrier, if available.

10.5.3.2.2 If the Provider presents to the Contractor a valid denial from the Member's primary carrier, the Contractor shall not recoup the claim. For the purposes of this requirement, a denial is considered valid if the primary carrier cites any of the following instances as reason for the denial:

10.5.3.2.2.1 Applied to Deductible

10.5.3.2.2.2 Applied to Coinsurance

10.5.3.2.2.3 Applied to Co-payment

10.5.3.2.2.4 Lifetime benefit maximum has been reached

10.5.3.2.2.5 Date of Service prior to effective date

10.5.3.2.2.6 Date of Service after termination date

10.5.3.2.2.7 Past the timely filing deadline

10.5.3.2.2.8 Out of Network (and no out of network benefits)

10.5.3.2.2.9 Non-covered service

10.5.4 The Contractor may debit Provider accounts if refunds are not made within the timeframes outlined in this Section of the contract.

10.5.5 The Contractor may challenge the validity and/or accuracy of a denial of payment made by an insurance company.

10.6 Casualty Recoveries

Casualty recovery's function is to identify and recover monies paid on behalf of a Medicaid Member for services resulting from any type of accident for which a Third Party is liable. Accident types include, but are not limited to, automobile, slip and fall, medical malpractice, and assault.

The Contractor shall pursue casualty recoveries just as they are required to pursue other types of TPL Claims. However, the Department shall retain the responsibility for handling any casualty Claims that involve product liability, class action suits, multi-state litigation, and Special Needs Trusts. If the Contractor is notified or otherwise becomes aware of casualty Claims involving product liability, class action suits, multi-state litigation, and/or a Special Needs Trust, the Contractor shall forward the Claims to the Department by the end of the next Business Day.

The Contractor shall:

10.6.1 Notify the Department at least thirty (30) calendar days prior to changing Casualty Vendors.

10.6.2 Seek prior approval from the Department before contracting with a Casualty Vendor.

10.6.3 Provide contact information for the Casualty Vendor to the Department.

10.6.4 Generate (preferably automated) accident questionnaires using analysis of trauma diagnoses and surgical procedure codes.

10.6.4.1 Responses shall be investigated for possible casualty recovery and for indications of other health insurance.

10.6.5 Casualty Case Management

The purpose of Casualty Case Management is to ensure the Contractor is meeting TPL requirements and coordinating with the Department to effectively pursue the recovery of funds paid by the Department for trauma-related health claims when a third party is responsible for payment of those claims.

The Contractor, or its Subcontractor(s), for the purposes of Casualty Case Management, shall:

10.6.5.1 Respond to all attorney correspondence within ten (10) business days with the requested information.

10.6.5.2 Respond to all carrier correspondence within ten (10) business days with the requested information.

10.6.5.3 All returned accident questionnaires with responses detailing a possible casualty recovery shall be brought into the workflow and responded to within ten (10) business days of receipt.

10.6.5.4 Answer telephone calls daily. The Contractor shall make best efforts to return voicemails within 24 hours.

10.6.5.5 Failure to comply with the requirements herein may result in liquidated damages, sanctions, and/or corrective action as outlined in Section 18 of this contract.

10.7 Retroactive Eligibility for Medicare

The Department or its designee shall notify the CONTRACTOR when Members become retroactively eligible for Medicare. The Department shall recoup premium payments that do not reflect the dual status of the Member. The Contractor shall recover its payment from the provider that was paid the full contract rate notifying the provider of the Medicare eligibility.

The Contractor shall:

10.7.1 Invoice institutional and professional medical Providers as soon as the Contractor becomes aware of the Member's retroactive Medicare coverage (Retro Medicare). Providers are expected

to file the affected Claims to Medicare within thirty calendar (30) days of the Contractor's invoice.

10.7.2 Send a letter indicating that the Provider account will be debited. The letter should identify the Medicare-eligible Member, dates of service, as well as the date of the automated adjustment and mechanism for identification of the debit(s).

10.7.3 Ensure that Providers have the option of filing a Claim to the Contractor for consideration of any additional payment toward any applicable Medicare coinsurance and deductible.

10.7.3.1 After filing a Claim to Medicare, a Provider's request for reconsideration of the debit shall be considered by the Contractor so long as that request was received within ninety (90) calendar days of the debit.

10.7.3.2 If Medicare has denied the Claim, the Contractor shall allow the Provider to submit a Claim to the Contractor for payment, along with the Medicare denial.

10.7.4 Ensure that each procedure billed by the Provider shall be individually assessed and the Contractor's recovery process shall not include procedure codes that are not Medicare covered.

10.8 Third-Party Liability Reporting Disenrollment Requests

The CONTRACTOR shall submit a Disenrollment request if it has identified the presence of Third Party resource that results in the individual being ineligible for Enrollment in CONTRACTOR's Health Plan.

10.9 Third-Party Liability Recoveries by the Department

10.9.1 The Department reserves the right to attempt recovery independent of any action by the CONTRACTOR.

10.9.1.1 After one hundred and eighty (180) Days from the date of payment of a Claim subject to recovery for health recovery activities.

10.9.1.2 After three hundred and sixty-five (365) Days from the date of payment of a Claim subject to recovery for casualty recovery activities.

10.9.2 The Department shall retain all funds received from any state-initiated recovery or Subrogation action.

10.10 Systems and Reporting Requirements

The CONTRACTOR shall report all third-party cost-avoidance and recoveries for its Members as outlined below and in the format specified in the Managed Care Report Companion Guide.

10.10.1 The CONTRACTOR shall provide a monthly submission of TPL recoveries and include the following information:

10.10.1.1 Inform the Department of the probable existence of Third Party coverage that is not known to the Department and any change or lapse in the Member's Third Party insurance coverage of which the CONTRACTOR has noticed.

10.10.1.2 Specify the amounts cost-avoided and amounts collected post-payment through retro recovery process.

10.10.1.3 For any Third Party recoveries collected after the reporting period for Encounter data, the CONTRACTOR shall report this information to the Department and revise the next submission of the Encounter data report to either void or adjust

the Encounter as appropriate.

10.10.1.4 The CONTRACTOR shall be required to include the collections and Claims information in the Encounter data submitted to the Department, including any retrospective findings via Encounter adjustments.

10.10.2 The Contractor shall maintain systems that support activities related to identification of Third- Party Resources, cost avoidance, collection, recovery of Title XIX expenditures from Third Party Resources, posting of Benefits recovered, and federal reporting requirements.

10.10.3 The Contractor's systems shall support the Contractor's ability to perform all TPL requirements as outlined in this Section of the contract to include, but shall not be limited to:

10.10.3.1 Identify and maintain third-party liability resources.

10.10.3.2 Identify and maintain third-party carrier data.

10.10.3.3 Cost avoid Claims as appropriate to avoid payment when third-party carrier exist.

10.10.3.4 Report all payment avoided due to established third-party liability.

10.10.3.5 Produce bills to Provider or carriers for recovery of payments made prior to identification of a third-party resource.

10.10.3.6 Produce bills to Providers for retroactive Medicare-eligible Member's.

10.10.3.7 Account for receipts from Providers or carriers.

10.10.3.8 Produce accident questionnaires for designated trauma diagnosis codes and post the initial questionnaire to stop the production of a second one.

10.10.3.9 Track and follow-up on all automated TPL correspondence.

Section 11. PROGRAM INTEGRITY

11.1 General Requirements

The state Medicaid agency is responsible for protecting the integrity of the Medicaid Program, regardless of the service delivery system. To this end, the Department and its respective Bureaus engage in activities designed to protect the integrity of the Medicaid program and identify, prevent, and recover losses from Fraud, Waste, and Abuse (FWA).

Investigations of Members for potential Fraud are pursued entirely by the Department in conjunction with, and under specific contractual provisions between, the Department and the South Carolina Attorney General's (SCAG) Office. The CONTRACTOR must refer Members suspected of potential Fraud to the Department in accordance with the Managed Care Process and Procedures Manual.

Per 42 CFR § 438.608(a), the CONTRACTOR, or Subcontractor to the extent that the Subcontractor has delegated responsibility by the CONTRACTOR for coverage of services and payment of claims under the contract between the Department and the CONTRACTOR, must implement and maintain arrangements or procedures that are designed to detect and prevent FWA.

The CONTRACTOR shall:

11.1.1 Develop and maintain a Compliance Plan to guard against FWA (42 CFR § 438.608(a) (1)) and in accordance with Section 11.2 of the Managed Care Process and Procedure Manual

11.1.2 Have sufficient organizational capacity (administrative and management arrangements or procedures) to guard against FWA (42 CFR § 438.608(a)). Specifically, adequate staffing and resources needed to fulfill the program integrity and compliance requirements of this contract; to investigate all reported incidents; and to develop and implement the necessary systems and procedures to assist the CONTRACTOR in preventing and detecting potential FWA. Refer to *Section 2.2 Staffing Requirements* of this contract.

11.1.3 Have surveillance and utilization control programs and procedures in accordance with 42 CFR §§ 456.3, 456.4, and 456.23 to safeguard the Medicaid funds against unnecessary or inappropriate use of Medicaid services and against improper payments.

11.1.4 Establish functions and activities governing the Department's Bureau of Program Integrity (PI) to reduce the incidence of FWA and comply with all state and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, §§. 1128, 1902, 1903, and 1932; 42 CFR §§ 431, 433, 434, 435, 438, 441, 447, 455; and 45 CFR Part 74.

11.1.5 Have provisions for recovering funds from Providers.

11.1.6 Make a prompt referral of any suspicion of potential FWA identified during a preliminary investigation directly to PI. The Contractor shall make a prompt referral of any potential criminal activity identified during a preliminary investigation, but outside the scope of program integrity, directly to the Vulnerable Adults and Medicaid Provider Fraud Unit (VAMPF). Refer to *Section 11* of the Managed Care Process and Procedure Manual. (42 CFR § 438.608(a)(7))

11.1.7 Have the discretion and ability to place a Provider suspected of FWA on prepayment review or otherwise take preventative actions as necessary to prevent further loss of funds.

11.1.8 Coordinate with the Department for Provider or Member complaints received from the Fraud and Abuse hotline or email, as directed in the Managed Care Process and Procedure Manual.

11.1.9 Cooperate fully in any investigation or prosecution by any duly authorized federal or state government agency, whether administrative, civil, or criminal.

11.1.10 Upon notification by the Department that a Provider has been placed on a payment suspension due to a Credible Allegation of Fraud (CAF) pursuant to 42 CFR § 455.23, the CONTRACTOR must also suspend the payments to that Provider and/or administrative entities involved. The CONTRACTOR shall effectuate this suspension as soon as practicable. (42 CFR § 438.608(a)(8))

11.1.10.1 Once the payment suspension has been lifted, prior to releasing the withheld funds to the Provider, the CONTRACTOR must have provisions to calculate and first apply the withheld funds towards the Provider's established overpayment. An established overpayment is one in which the MCO has identified an overpayment amount that is owed by the provider, and after all provider appeal rights have been completed.

11.1.10.2 If the CONTRACTOR fails to apply withheld funds to the Provider's established overpayment prior to releasing the withheld funds to the Provider, the Department may seek recovery directly from the CONTRACTOR for the amount that should have been withheld and applied to the Provider's overpayment.

11.1.11 Upon notification by the Department that a Provider has been placed on prepayment review by the Department, the CONTRACTOR must also place the Provider on prepayment review to the same extent as the Department. The CONTRACTOR shall effectuate this prepayment review as soon as practicable.

11.1.12 Withhold payment to a Provider as warranted for recoupment.

11.1.13 Implement and maintain arrangements or procedures for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. Identified and recovered overpayments shall be reported within thirty (30) business days of discovery. (42 CFR §§ 438.608(a)(2), 438.608(d)(3) and 457.1285)

11.1.13.1 The CONTRACTOR shall use the terms for Discovery of Overpayments found within the Managed Care Report Companion Guide and as reported on the Overpayments List on the secure PI website.

11.1.14 Have the right to recover directly from Providers for the reviews and investigations the CONTRACTOR conducts.

11.1.15 Reimburse the Department for any federal disallowances or sanctions imposed on the Department because of the CONTRACTOR's failure to abide by the terms of the contract.

11.1.16 Produce and timely submit all reports arising from the performance of requirements in *Section 11* of the Contract and/or contained in the Managed Care Process and Procedure Manual and/or the Managed Care Report Companion Guide.

11.1.16.1 Each report's data cells MUST contain the requested data as described in the Managed Care Process and Procedure Manual.

11.1.16.2 If a report is rejected for non-compliance, refer to *Section 18* of this Contract.

11.1.17 Generate individual notices (a.k.a. Beneficiary Explanation of Medicaid Benefits (BEOMB)) within forty-five (45) Calendar Days of the claim payment date to all, or a statistically valid sample of, the Medicaid Managed Care Members who received services under the CONTRACTOR's Health Plan. (42 CFR § 438.608(a)(5)) The notice must not specify confidential services as defined by the Department, within the Managed Care Process and Procedure Manual, and must not be sent if the only service furnished was confidential. The notice must specify:

11.1.17.1 The purpose of the letter is to verify receipt of services,

11.1.17.2 The process by which a Member may report any discrepancies in services received.

11.1.17.3 The service furnished,

11.1.17.4 The name of the Provider furnishing the service,

11.1.17.5 The date on which the service was furnished, and

11.1.17.6 The amount of the payment made under the Plan for the service.

11.1.18 Manage a Statewide Pharmacy Lock-In Program (SPLIP) in accordance with 42 CFR § 431.54(e), and as further outlined in Section 11.9 Statewide Pharmacy Lock-In Program (SPLIP) of the Managed Care Process and Procedure Manual.

11.1.19 Not provide any payments for items or services provided to any financial institution or entity located outside of the United States (U.S.) in accordance with Section 6505 of the Affordable Care Act which amends section 1902(a) of the Social Security Act (the Act). The contract shall not pay for claims for services, including telemedicine and pharmacy, submitted by network Providers, out-of-network Providers, Subcontractors, or financial institutions located outside of the United States. Any payments made to such individuals or entities that are not eligible for payment and must be excluded from development of Actuarially Sound Capitation Rates.

11.1.20 Be subject to an annual review by PI, or its designees to review the CONTRACTOR's or Subcontractor's performance to ensure compliance with this Contract and in accordance with the Managed Care Process and Procedure Manual.

11.1.20.1 Such reviews may include, but shall not be limited to: interviews, to include owners, officers and managing employees; collection and/or copying of original, electronic or hardcopy records; verification of audit trails; verification of Provider and employee credentials and licenses; review of program integrity and

special investigation unit activities; demonstration of case monitoring systems; review of provider case files; production of fiscal records for tracking overpayment collections; demonstration of sanction monitoring; data mining processes; and any requested documentation supporting the implementation of and compliance with both the CONTRACTOR's FWA Plan and Compliance Plan.

11.1.21 For purposes of this Section, the phrase "the Department or its "designees" may include, but shall not be limited to CMS, United States Department of Health and Human Services (DHHS), OIG, RAC, UPIC, SCAG and any other appropriate law enforcement entity.

11.1.22 Failure on the part of the CONTRACTOR to adhere to the provisions set forth within this section of the Contract, in part or in whole, may result in liquidated damages and/or in sanctions as outlined in *Section 18* of this Contract, up to and including the termination of this Contract.

11.2 Compliance Plan Requirements

The CONTRACTOR shall create and maintain a Compliance Plan that addresses, at a minimum, the following requirements:

11.2.1 Written Policies, Procedures and Standards of Conduct

The Compliance Plan shall include written policies, procedures, and standards of conduct that articulate the CONTRACTOR's commitment to comply with all applicable requirements and standards under the contract, and all applicable federal and state standards and regulations. (42 CFR § 438.608(a)(1)(i)) The Compliance Plan shall, at a minimum, include:

11.2.1.1 A list of automated prepayment claims edits designed to ensure proper payment of claims and prevent payment of improper claims.

11.2.1.2 Internal operating procedures for desk reviews or post-payment review of claims.

11.2.1.3 Reference in Provider and Member materials regarding FWA referrals.

11.2.1.4 Pursuant to the Deficit Reduction Act of 2005 (DRA) and 42 CFR § 438.608(a)(6), the CONTRACTOR shall have written policies and provide training and education for all employees detailing:

11.2.1.4.1 The Federal False Claims Act provisions,

11.2.1.4.2 The administrative remedies for false claims and statements,

11.2.1.4.3 Any federal or state laws described in 1902(a)(68) of the Act, relating to civil or criminal penalties for false claims and statements, and

11.2.1.4.4 The whistleblower protections under such laws.

11.2.2 Compliance Officer, Program Integrity Coordinator and Staff

The CONTRACTOR shall designate and identify the following staff positions in the Compliance Plan:

11.2.2.1 Identification of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the Board of Directors. (42 CFR § 438.608(a)(1)(ii))

11.2.2.2 Identification of a Program Integrity Coordinator who is a staff member within the Special Investigative Unit (SIU) with hands on knowledge and decision-making capabilities regarding program integrity, to coordinate FWA activities and efforts with PI.

11.2.2.3 Inclusion of an organizational chart in the Compliance Plan that identifies the names and job titles for all CONTRACTOR staff specified in *Section 2, Exhibit 2*; to include status of in-state and full time equivalent (FTE) and required designations.

11.2.3 Regulatory Compliance Committee

The CONTRACTOR shall establish of a regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the CONTRACTOR's compliance program and its compliance with the requirements under this contract. (42 CFR § 438.608(a)(1)(iii)) The regulatory Compliance Committee shall be made up of, at a minimum, the Compliance Officer, a budgetary official and other executive official with the authority to commit resources. The regulatory Compliance Committee will assist the Compliance Officer in monitoring, reviewing and assessing the effectiveness of the compliance program and timeliness of reporting.

11.2.4 Training and Education

The Compliance Plan shall outline training and education for the Compliance Officer, the CONTRACTOR's senior management and the CONTRACTOR's employees and Subcontractors for the federal and state standards and requirements under this contract. (42 CFR § 438.608(a)(1)(iv)). The training and education activities shall, at a minimum, address the following requirements:

11.2.4.1 Outline activities proposed for the next reporting year regarding employee education of federal and state laws and regulations related to Medicaid program integrity.

11.2.4.2 Ensure that all of its officers, directors, managers, and employees know and understand the provisions of the CONTRACTOR's Fraud and Abuse Plan.

11.2.5 Lines of Communication

Effective lines of communication between the Compliance Officer and the CONTRACTOR's employees, Subcontractors, and Providers shall be established, clearly explained, and managed. (42 CFR § 438.608(a)(1)(v))

The CONTRACTOR shall:

11.2.5.1 Describe the provisions for how an individual would confidentially report CONTRACTOR violations; the report format, to whom the report is sent, method of reporting, etc.

11.2.5.2 Include methods to ensure that the identities of individuals reporting violations of the CONTRACTOR are protected and that there is no retaliation against such persons.

11.2.5.3 Include specific and detailed internal procedures for officers, directors, managers, and employees for detecting, reporting, and investigating Compliance Plan violations.

11.2.6 Enforcement & Accessibility

The CONTRACTOR shall enforce standards for the CONTRACTOR's employees through well publicized disciplinary guidelines. (42 CFR § 438.608(a)(1)(vi))

11.2.7 Internal Monitoring and Auditing

The CONTRACTOR shall establish procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risk, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Contract. (42 CFR § 438.608(a)(1)(vii))

11.2.8 Response & Corrective Action

The CONTRACTOR shall develop provisions for prompt response to detected offenses, and corrective action initiatives related to this Contract.

11.2.9 Data Mining, Analysis and Reporting

The Compliance Plan shall describe the CONTRACTOR's process for conducting analyses of its Provider and utilization data. This description must comply with the following standards:

11.2.9.1 A general description of the process for data mining and analyses performed by the CONTRACTOR,

11.2.9.2 A description of the individual reports, their purpose, objectives, and frequencies as associated with all FWA activities and requirements.

11.2.10 Internal Exclusion Verification

The Compliance Plan shall detail the process used by the CONTRACTOR to confirm the identity and determine the exclusion status of their Subcontractors, as well as any person with an ownership or control interest, or who is an agent or managing employee of the CONTRACTOR by checking federal databases during enrollment and revalidation. These

databases may include the Social Security Administration's Death Master File, the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the Department or Secretary of Health and Human Services may prescribe (e.g. Department's SC List of Excluded Providers). Such processes must be consistent with the Managed Care Process and Procedure Manual. (42 CFR § 438.602(d))

11.2.10.1 The CONTRACTOR shall consult the LEIE, SAM (formerly EPLS) no less frequently than monthly.

11.2.10.2 If the CONTRACTOR determines a match, it shall promptly notify PI and take any necessary actions consistent with 42 CFR § 438.610.

11.2.11 Submission of the Compliance Plan to the Department's Bureau of Program Integrity

The CONTRACTOR shall submit the Compliance Plan to PI in adherence to the following reporting requirements:

11.2.11.1 Submission of an electronic copy of the Compliance Plan within a ninety (90) Calendar Day period after the full execution of this contract, and annually thereafter,

11.2.11.2 PI shall provide notice of approval or request for modifications to the CONTRACTOR within sixty (60) Calendar Days of receipt.

11.2.11.3 The CONTRACTOR shall respond to the PI's request for modifications within twenty-one (21) Business Days from receipt of the request for modifications. This response shall act as the CONTRACTOR's final submission.

11.2.11.3.1 For additional modifications requested by PI, both the CONTRACTOR and PI shall have twenty-one (21) Business Days to respond.

11.2.11.4 PI shall respond to the CONTRACTOR's final submission within twenty-one (21) Business Days of receipt of the Compliance Plan.

11.3 CONTRACTOR's Controls

The CONTRACTOR shall have specific controls in place for prevention and detection of potential or suspected FWA, including but not limited to the following:

11.3.1 Data mining capable of validating, trending and querying claims paid on behalf of Medicaid Members in an effort to identify FWA;

11.3.2 Provider reviews;

11.3.3 Quality assurance/utilization reviews of hospital Providers. The CONTRACTOR shall have programs for quality assurances which provide both prepayment and post payment review of hospital services, including a program for prior authorizations of inpatient, hospital stays, and surgeries;

11.3.4 Pharmacy audits or reviews, if conducted by the CONTRACTOR and/or its designees, such as a Pharmacy Benefits Manager (PBM), to determine compliance with the Contractor's Pharmacy Benefits program;

11.3.5 Automated prepayment claims edits designed to ensure proper payment of claims and prevent fraudulent claims;

11.3.6 Provider prepayment review process;

11.3.7 Reports of Provider profiling and credentialing used to aid program and payment integrity reviews;

11.3.8 References in Provider and Member materials regarding how to report fraud and abuse referrals.

11.4 Reviews and Investigations

11.4.1 The CONTRACTOR shall conduct post payment review and recovery activities for the purposes of FWA activities with respect to provider payments made under the Medicaid Program. These activities shall not to exceed three (3) years from the last adjudication date of the claim unless the CONTRACTOR requests and receives written permission from PI to extend the recovery period.

11.4.1.1 The CONTRACTOR shall conduct a minimum number of program integrity related Provider onsite reviews per State Fiscal Year as established in the Managed Care Process and Procedure Manual.

11.4.1.2 During a review, the Provider is required to submit all requested records by the deadline given by the CONTRACTOR and in accordance with the Managed Care Process and Procedure Manual.

11.4.2 Vetting Forms shall be sent to the CONTRACTOR for provider reviews conducted by the Department resulting in an overpayment to be collected from the provider. The Department or its designees may at any time, and for any disclosed or undisclosed reason, initiate a review and/or investigation of any claims received by the CONTRACTOR for adjudication. Such review may include, but shall not be limited to, Member interviews, Provider interviews including owners, officers and managing employees, Provider's non-management employee interviews, collection of original records, collection or copying of electronic and/or hardcopy records, access to electronic audit trails, verification of Provider and employee credentials including any required licenses.

11.4.2.1 For purposes of this Section, “record" shall mean any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the entity into a reasonably usable form.

11.4.2.2 The Department or its designees shall have the sole discretion to determine the Provider review location and whether to perform an announced or unannounced Provider on-site visit.

11.4.2.3 Upon request by the Department or its designees, the CONTRACTOR shall provide all claims that were either paid, denied, adjusted, voided, and/or replaced for any Member and/or Provider selected for post payment review within the timeframe, manner, and customized format as specified by the Department.

11.4.2.4 Upon request, the CONTRACTOR shall be responsible for promptly vetting the review and/or investigative outcomes performed by the Department or its designees within the timeframes established in the Managed Care Process and Procedure Manual.

11.4.3 If requested by the Department or its designees, the CONTRACTOR shall take action to recoup all improper payments within thirty (30) Calendar Days of notification by the Department.

11.4.4 In the event of an established Provider overpayment or underpayment, the CONTRACTOR shall comply when asked to adjust, void, or replace, as appropriate, each encounter claim to reflect the proper claim adjudication.

11.4.5 A recovery of an overpayment by either the CONTRACTOR or the Department shall not be construed to prohibit an investigation or prosecution, nor prohibit from consideration any allegations of fraud or abuse arising from such overpayment.

11.5 Referral Coordination and Cooperation

11.5.1 The CONTRACTOR shall fully cooperate with the Department or its designees in their performance of any review undertaken and may involve, but shall not be limited to:

11.5.1.1 Data sharing and joint review of Providers that provide Medicaid services in either managed care only or both fee-for-service (FFS) and managed care environments.

11.5.1.2 Performance of data analysis by the CONTRACTOR as requested by the Department or its designees in support of FWA efforts.

11.5.1.3 Access to the CONTRACTOR's proprietary fee schedules, Provider agreements and/or contracts, Provider banking records, trading partner agreements, Provider credentialing information and any applicable Subcontracts.

11.5.1.4 Access to the CONTRACTOR's Provider manuals, to include all past versions effective during the period of the review and policies and procedures.

11.5.1.5 Access to interview the CONTRACTOR’s employees and consultants, including but not limited to, those with expertise in the administration of the program and/or in medical or pharmaceutical questions, or in any matter related to an investigation.

11.5.1.6 The CONTRACTOR's PI Coordinator must review with PI the CONTRACTOR's post payment reviews conducted, Providers placed on prepayment review, fraud referrals and Providers who are engaged in a dispute resolution process as a result of FWA activities at a frequency and time determined by the Department.

11.5.1.7 Attendance at all PI scheduled meetings is mandatory in person by both the CONTRACTOR's Compliance Officer and the PI Coordinator. In the event either the Compliance Officer or the PI Coordinator have a scheduling conflict, the Compliance Officer must notify PI's Operations and Managed Care Oversight Manager and assign an alternate participant for attendance at the meeting.

11.5.1.8 The CONTRACTOR's Compliance Officer, PI Coordinator, and CONTRACTOR's program integrity staff shall meet at scheduled intervals with the Department's PI staff to discuss cases and fraud and abuse referrals.

11.5.2 In the event the CONTRACTOR's network Provider is investigated or prosecuted by any duly authorized government agency, whether administrative, civil, or criminal, the CONTRACTOR shall cooperate in that investigation as needed.

11.5.3 The CONTRACTOR shall report annually to the Department on their recoveries of overpayments and improper payments identified in accordance with the Managed Care Process and Procedure Manual and the Managed Care Report Companion Guide.

11.6 Overpayments, Recoveries, and Refunds

11.6.1 General Requirements

11.6.1.1 Upon recovery of an established overpayment, the CONTRACTOR shall report the recovery to PI on the Fraud, Waste and Abuse Quarterly Report and the Overpayment List on the secure PI website as specified in the Managed Care Process and Procedure Manual and the Managed Care Report Companion Guide.

11.6.1.2 The CONTRACTOR shall comply with Discovery of Overpayment requirements as defined in 42 CFR § 433.316(c) and (d).

11.6.2 Recoveries by Department

11.6.2.1 In the event the Department, either from restitutions, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil monetary penalty, a global civil settlement or judgment, or any other form of civil action, receives a monetary recovery from an entity, the entirety of such monetary recovery belongs exclusively to the Department and the CONTRACTOR has no claim to any portion of this recovery.

11.6.2.1.1 The CONTRACTOR is fully subrogated to the Department for all criminal and civil recoveries.

11.6.2.1.2 The Department shall retain all recoveries/penalties/civil settlements resulting from FWA cases pursued by the Department and/or the VAMPF, after the VAMPF deducts its fees and costs as appropriate.

11.6.2.2 The Department or its designees shall reserve the right to recover an established overpayment directly from any Medicaid Managed Care Provider, regardless of whether the Provider is considered an "in-network" or "out of network" Provider, for any audits, reviews or investigations that the Department or its designees may conduct.

11.6.2.2.1 When directed by the Department or the Bureau of Program Integrity, the CONTRACTOR shall offset a Provider's future payments to collect a Recoupment established by the Department or any of its authorized entities.

11.6.2.2.2 The CONTRACTOR shall remit to the Department funds offset as a result of this provision within thirty (30) Calendar Days of the offset occurrence in accordance with Managed Care Policies and Procedures Guide.

11.6.2.2.3 Such recoveries shall not be shared with the CONTRACTOR.

11.6.2.3 Vetting Form for Encounter Claims Data and/or Provider Information

11.6.2.3.1 Vetting Forms will be sent to the CONTRACTOR for Provider reviews conducted by the Department resulting in an overpayment to be collected from the Provider.

11.6.2.3.2 The Department shall send a Vetting Form to the CONTRACTOR to vet paid encounter claims when the Department has identified an overpayment made by the CONTRACTOR to a Provider.

11.6.2.3.3 Upon receipt of the Vetting Form, the CONTRACTOR has up to thirty (30) Calendar Days to return the completed form to the Department in accordance with the Managed Care Report Companion Guide. However, if the Vetting request is initiated for an external stakeholder, such as a Unified Program Integrity Contractor (UPIC) or Recovery Audit Contractor (RAC), the Department will require a shorter deadline of fifteen (15) Calendar Days.

11.6.2.3.4 If the Department or its designees performs a review of encounter claims paid by the CONTRACTOR and identifies an overpayment, the Department shall send notice to the CONTRACTOR and shall collect and retain any overpayment from the CONTRACTOR.

11.6.2.3.5 Upon receipt of the Vetting Form, if the CONTRACTOR does not agree that an overpayment has occurred or has a reason as to why the overpayment was not acted upon, the CONTRACTOR may dispute the

overpayment in writing, to the Department's PI Bureau Chief of designee within 30 Calendar Days.

11.6.2.3.5.1 The dispute shall state the reason the CONTRACTOR believes an overpayment did not occur or was not collected and may present additional information to support the CONTRACTOR's position.

11.6.2.3.5.2 Failure of the CONTRACTOR to meet contractual, or state or federal requirements will not be an acceptable basis for Overpayment disputes.

11.6.2.3.5.3 The Department will have the sole discretion to uphold, overturn, or amend an identified overpayment disputed by the CONTRACTOR.

11.6.2.3.5.4 The CONTRACTOR shall be notified in writing of the decision of the Department.

11.6.2.3.6 The CONTRACTOR shall remit the amount of the overpayment within ninety (90) Calendar Days of notification by the Department; or if the overpayment has been disputed, the CONTRACTOR will remit the amount within sixty (60) Calendar Days of notification of a decision by the Department.

11.6.2.3.7 The CONTRACTOR may request an extension of the remittance with justification to the Department's PI Bureau Chief or designee prior to the deadline.

11.6.2.3.8 Failure to remit an amount within the timeframe will result in the Department collecting the amount from the CONTRACTOR's Capitation Payment as allowed under this Section of the Contract and imposing a $500.00 penalty per incident.

11.6.3 Recoveries by CONTRACTOR

11.6.3.1 Unless otherwise specified in this contract, the CONTRACTOR shall have the right to recover directly from Providers for claims paid by the CONTRACTOR for the reviews and investigations the CONTRACTOR conducts or for overpayments identified by the Department.

11.6.3.1.1 The CONTRACTOR shall not recover directly from Providers for claims paid by the CONTRACTOR after a review or investigation is referred to the VAMPF or results in an investigation by any authorized law enforcement entity unless the CONTRACTOR receives prior permission from VAMPF or other law enforcement entity in the form and manner established in the Managed Care Process and Procedure Manual.

11.6.3.1.2 The CONTRACTOR may retain the recoveries of an overpayment from Providers to include, but not limited to, the following situations:

11.6.3.1.2.1 Payments made to a Provider that were otherwise excluded from participation in the Medicaid Program and subsequently recovered from that Provider by the CONTRACTOR.

11.6.3.1.2.2 Payments made to a Provider due to FWA and subsequently recovered from that Provider by the CONTRACTOR.

11.6.4 Department Collection of Amounts Owed

11.6.4.1 The Department reserves the right to collect interest on unpaid balances beginning thirty (30) Calendar Days from the date of initial notification to the CONTRACTOR and after sixty (60) Calendar Days upon notification to a Provider.

11.6.4.2 The rate of interest charged will be the same as that fixed by the Secretary of the United States Treasury as provided for in 45 CFR § 30.18. This rate may be revised quarterly by the Secretary of the Treasury and shall be published by DHHS in the Federal Register.

11.6.4.3 The Department reserves the right to collect any amount owed to the Department as a result of the following, to include, but shall not be limited to: audits or reviews, overpayments, errors in payment, penalties, and liquidated damages. These amounts shall be collected, by deducting the amount owed from the next monthly Capitation Payment due to the CONTRACTOR.

11.6.4.4 The CONTRACTOR shall reimburse the Department for any federal disallowances or sanctions imposed on the Department as a result of the CONTRACTOR's failure to abide by the terms of the contract.

11.6.4.5 The CONTRACTOR will be subject to any additional conditions or restrictions placed on the Department by DHHS as a result of the disallowance.

11.6.4.6 The CONTRACTOR shall provide any information concerning encounter data, data from its claims processing and financial systems, or other data regarding Medicaid Benefits paid on behalf of its Members, as requested by the Department, its authorized entities, or the SCAG.

11.7 Cooperation and Support in Investigations, Hearings, and Disputes

The Contractor shall cooperate fully with the Department, DHHS, the VAMPF, and any other authorized local, state, and federal agencies or law enforcement authorities in the investigation, documentation, and litigation of possible FWA cases or any other misconduct involving any of the duties and responsibilities performed by the CONTRACTOR under the contract. DHHS, its authorized representatives, and those of any other authorized local, state, or federal agency or law enforcement agency shall have access to the same records and information as does the Department.

11.7.1 The CONTRACTOR shall cooperate and participate in the resolution of state fair hearings and Provider disputes at the request of the Department.

11.7.2 The CONTRACTOR shall provide documentation and CONTRACTOR representatives/witnesses, and/or affidavits, as required by the Department, for such appeals/hearings.

11.8 Suspension of Payment Based on Credible Allegation of Fraud (CAF)

11.8.1 The CONTRACTOR must have a provision for suspension of payments to a Provider for which the Department determines there is a CAF in accordance with 42 CFR § 455.23 and42 CFR § 438.608(a)(8).

11.9 Prepayment Review

11.9.1 The CONTRACTOR shall have a provision for full prepayment review for a Provider for which the Department initiates a full prepayment review to ensure claims presented meet the requirements of federal and state laws and regulations.

11.9.2 A provider shall only be removed from prepayment review when determined appropriate by PI.

11.10 Statewide Pharmacy Lock-in Program (SPLIP)

The CONTRACTOR shall implement and maintain a Statewide Pharmacy Lock-In Program (SPLIP), in which the Department will identify Members who are using pharmacy services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the Department, in conformance with 42 CFR § 431.54(e), and as promulgated in the Managed Care Process and Procedure Manual.

11.10.1 Selection

The Department shall develop and publish statewide criteria for evaluating all Medicaid members as eligible candidates in the SPLIP.

11.10.1.1 On a quarterly basis, the Department shall select members for enrollment into the SPLIP based on the published criteria and shall generate utilization profiles for each selected member.

11.10.1.2 The CONTRACTOR may lock additional members into the SPLIP based on their own independent medical review or clinical criteria.

11.10.1.3 The CONTRACTOR shall conduct a second review to identify any member that would not benefit from the SPLIP due to complex drug therapy or other case management needs.

11.10.2 Letters / Notifications

The Department shall create SPLIP template letters and instructions for the member and designated pharmacy, located in the Managed Care Report Companion Guide. Prior to distribution, the Department must approve any and all modifications to the templates by the CONTRACTOR.

The CONTRACTOR shall:

11.10.2.1 Be responsible for notifying the member of their lock in status and their designated pharmacy. The Member Initial Notification Letter and instructions shall be sent via Certified Mail no later than thirty (30) Calendar Days prior to the effective lock-in date. The letter shall include the following:

11.10.2.1.1 The Member's restricted period in the SPLIP as "Effective Date" to "Termination Date".

11.10.2.1.2 The Department's preselected designated pharmacy based on the Member's claim usage.

11.10.2.1.3 Instructions, and a deadline, for the Member to choose a pharmacy if their choice is different than the preselected pharmacy by the Department. All Members enrolled in the SPLIP must be allowed Provider choice.

11.10.2.1.4 Details on the Member's appeal rights.

11.10.2.2 Restrict the Members to a designated pharmacy no later than ninety (90) Calendar Days after the initial quarterly referral from the Department as long as a Member does not file an appeal. The established timeline in the Managed Care Process and Procedure Manual is recommended.

11.10.2.3 Have a process at the point-of-sale to "lock-in", or restrict, the Member to a designated pharmacy, therefore denying claims from all pharmacy Providers other than the designated pharmacy.

11.10.3 Designated Period / Participation

In the SPLIP, the Member shall be locked into a consecutive, restricted period.

The CONTRACTOR shall:

11.10.3.1 Initiate the lock in process and establish the restricted period in the Member Initial Notification Letter as "Effective Date" to "Termination Date".

11.10.3.2 Regardless of the reasoning for a Member's movement (e.g., between contracted Health Plans, or in and out of Medicaid eligibility), when a SPLIP Member is assigned to the CONTRACTOR, the CONTRACTOR shall be responsible for maintaining the Member's continued enrollment until the member's established "Termination Date", or disenrollment, whichever comes first.

11.10.3.3 If the CONTRACTOR receives a Member who is already in the SPLIP, the Department will notify the CONTRACTOR of the Member's enrollment, the restricted period, and the current designated lock in pharmacy.

11.10.3.4 The CONTRACTOR shall continue the restricted period, as established in the Initial Member Notification Letter, for continual lock-in of the Member and until the completion of the restricted period as established.

11.10.3.5 Be allowed to make an exception to allow for a seventy-two (72) hour emergency supply of medication to be filled by a pharmacy other than the Member's designated lock-in pharmacy. Such emergency supply shall be permitted to ensure the provision of necessary medication required on an interim/urgent basis and shall follow all emergency supply requirements as set forth in *Section 4* of this Contract.

11.10.3.6 Be required to maintain tracking of the SPLIP Members in a format established by the Department and containing the necessary data to effectively operate the SPLIP.

11.10.4 Appeal

The CONTRACTOR shall:

11.10.4.1 Facilitate an appeal process, in accordance with the requirements in *Section 9* of this Contract and the Managed Care Process and Procedure Manual, for the member regarding the claims reviewed in determining their lock-in selection.

11.10.4.2 Not implement a Member's pharmacy restriction until the appeal process has been completed. This includes the time period from when the Member files the appeal, including a state fair hearing, has run its course and a final decision is rendered.

11.10.5 Removal

At the end of the Member's restricted period, the CONTRACTOR shall remove the restricted status at the point-of-sale and the Member shall be notified in writing at least ten (10) days in advance.

11.11 Ownership and Control

11.11.1 The CONTRACTOR shall provide the Department with written disclosure on the identity and address of each person or corporation with an ownership or control interest as described in 42 CFR § 455.101, (Section 1124(a)(2)(A) of the Act; Section 1903(m)(2)(A)(viii) of the Act; 42 CFR § 438.602(c), 42 CFR § 455.100 – 104)

11.11.1.1 This information shall be provided to the Department on the approved Disclosure of Ownership and Control Interest Statement and due at any of the following times:

11.11.1.1.1 Upon the CONTRACTOR or disclosing entity submitting the application.

11.11.1.1.2 Upon the CONTRACTOR executing a contract.

11.11.1.1.3 Upon request by the Department during re-Validation of enrollment process under 42 CFR § 455.414

11.11.1.1.4 Within thirty-five (35) Calendar Days after any change in ownership of the disclosing entity.

11.11.1.2 The CONTRACTOR, at a minimum, shall provide all information as detailed in accordance with 42 CFR § 455.104.

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

11.12.1 The CONTRACTOR agrees to comply with all applicable provisions of 2 CFR Part 376 (2009, as amended) pertaining to debarment and/or suspension for all its employees, Subcontractors, and all Providers.

11.12.2 The CONTRACTOR is subject to and agrees to comply with all applicable provisions of 42 CFR 455.101. This applies to Providers who render, prescribe, order, or refer services to Medicaid Members. Federal regulations preclude reimbursement for any services ordered, prescribed, or rendered by a Provider who is currently excluded or terminated from direct and indirect participation in the South Carolina Medicaid Program or Federal Medicare Program.

11.12.2.1 A Member may purchase services provided, ordered, or prescribed by a suspended or terminated Provider, but no Medicaid funds nor Medicaid capitated payments from the CONTRACTOR can be used.

11.12.3 Any individual or entity that employs or contracts with an excluded Provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded Provider.

11.12.3.1 This prohibition applies even when the Medicaid payment itself is made to another Provider who is not excluded; for example, a pharmacy that fills a prescription written by an excluded doctor for a Medicaid Member cannot claim reimbursement from Medicaid for that prescription.

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

11.12.5 The CONTRACTOR shall ensure that no payments are made to any provider, whether an individual or entity, or employee, who is determined to be excluded, debarred or suspended from participation in Medicare, Medicaid, the state Children's Health Insurance Program (CHIP), and/or any other federal health care programs. (42 CFR § 438.214(d)(1))

11.12.6 The CONTRACTOR shall ensure that none of its Providers and Subcontractors has had a Medicaid contract with the Department that was terminated for cause of denied for cause, and/or suspended as a result of any action of CMS, the VAMPF, and/or the Department.

11.12.7 The CONTRACTOR shall report to the Department any Providers or Subcontractors that have been debarred, suspended, excluded, and/or terminated for cause from participation in Medicaid, Medicare, or any other federal program immediately upon discovery by using the appropriate referral form and in the form and manner established

in the Managed Care Process and Procedure Manual and Managed Care Report Companion Guide.

11.12.8 The CONTRACTOR shall report to the Department any Provider or Subcontractor whose billing privileges were revoked by the CONTRACTOR for program integrity reasons in the form and manner established in the Managed Care Process and Procedure Manual and Managed Care Report Companion Guide.

11.12.9 The CONTRACTOR shall notify PI and the Department whenever the CONTRACTOR denies a Provider's credentialing application for program integrity reasons or otherwise limits the ability of Providers to participate in the Medicaid Program for program integrity reasons in accordance with the Managed Care Process and Procedure Manual and Managed Care Report Companion Guide. The reasons shall include, but are not limited to, the following:

11.12.9.1 The CONTRACTOR denies Credentialing of any Provider that was terminated on or after January 1, 2011, by Medicare or another state's Medicaid or CHIP.

11.12.9.2 The CONTRACTOR denies or revokes Credentialing for a Provider who fails to permit access to CMS, its agents, or its designated contractors, or to the Department or its agents, or its designated contractors or to the CONTRACTOR, its agents, or its designated contractors, or authorized law enforcement entities to conduct unannounced on-site inspections of any and all Provider locations.

11.12.9.3 The CONTRACTOR determined that the Provider falsified Credentialing information provided to the CONTRACTOR.

11.12.9.4 The Provider's license to practice was suspended and/or revoked, or there are restrictions placed on his or her license such that the Provider would not be able to adequately serve Medicaid Members.

11.12.10 The CONTRACTOR shall screen all Providers and Subcontractors that are not South Carolina Medicaid Network Providers to determine whether they have been excluded or debarred from participation in Medicare, Medicaid, the state CHIP, and/or all federal health care programs.

The CONTRACTOR shall, through the following mechanisms:

11.12.10.1 Search the List of Excluded Individuals and Entities (LEIE) website located at https://oig.hhs.gov/exclusions/index.asp.

11.12.10.2 Search the Department's list of Providers who are terminated, suspended, or otherwise excluded from participation in the Medicaid Program, available on the Department's website.

11.12.10.3 Search the "System for Award Management" (formerly the Excluded Parties List Service) administered by the General Services Administration.

11.12.10.4 Consult the appropriate databases to confirm identity upon enrollment and reenrollment.

11.12.10.5 Consult the LEIE, SAM (formerly EPLS) and the Department's List no less frequently than monthly.

11.12.10.6 Make available to the Department upon request a monthly electronic record of all exclusion and debarment database searches it is required to conduct monthly.

11.12.10.7 The CONTRACTOR shall perform the same screening of employees and administrative Subcontractors as required in *Section 2* of this Contract.

11.12.11 In accordance with 42 CFR § 438.808, Federal Financial Participation (FFP) is not available for any amounts paid to the Contractor, Subcontractor or Providers that could be excluded under Section 1128(b)(8) of the Act.

11.13 Prohibited Affiliations with Individuals Debarred by Federal Agencies

11.13.1 The CONTRACTOR may not knowingly have a relationship with the following:

11.13.1.1 An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non- procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

11.13.1.2 An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR § 2.101.

11.13.2 The CONTRACTOR shall not have a relationship with an individual or entity that is excluded from participation in any federal health care program under Section 1128 and 1128A of the Act.

11.13.3 Under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, the relationships described above shall include the following:

11.13.3.1 A director, officer, or partner of the CONTRACTOR;

11.13.3.2 A Subcontractor of the CONTRACTOR, as governed by 42 CFR § 438.230;

11.13.3.3 A person with a beneficial ownership of five (5) percent or more in the CONTRACTOR's equity;

11.13.3.4 A network Provider or a person with an employment, consulting, or other arrangement with the CONTRACTOR for the provision of items and services that are significant and material to the CONTRACTOR's obligations under its contract with the Department.

11.13.4 In accordance with 42 CFR § 438.610, if the Department finds that the CONTRACTOR is not in compliance with this Section of this contract the Department;

11.13.4.1 Shall notify the Secretary of the noncompliance;

11.13.4.2 May continue an existing contract with the CONTRACTOR unless the Secretary directs otherwise;

11.13.4.3 May not renew or otherwise extend the duration of the existing contract with the CONTRACTOR unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the contract despite the prohibited affiliations.

11.13.4.4 Nothing in this Section shall be construed to limit or otherwise affect any remedies available to the U.S. under Sections 1128, 1128A or 1128B of the Social Security Act.

11.14 Provider Termination / Denial of Credentials

11.14.1 Providers who have been terminated by any state or federal controlling agency for Medicaid and/or Medicare Fraud and Abuse and/or are currently under exclusion shall not be allowed to participate in the Medicaid Managed Care Program.

11.14.2 The CONTRACTOR is required to terminate Providers/Subcontractors for cause in accordance with federal regulations found at 42 CFR § 455.416 and Department policies, and to report these terminations in a manner determined by the Department.

11.14.3 The CONTRACTOR shall notify the Department when the CONTRACTOR receives information about a change in a Provider's circumstances that may affect the Provider's ability to participate. This includes, but is not limited to, termination of the Provider contract or denial of a Provider credentialing application for Program Integrity-related reasons that otherwise limits the ability of Providers to participate in the program for program integrity reasons. (42 CFR § 438.608(a)(3))

11.15 Information Related to Business Transactions

11.15.1 The CONTRACTOR agrees to furnish to the Department or, upon request, the Secretary of DHHS, the Inspector General of DHHS, and the Comptroller General of DHHS a description of transactions between the CONTRACTOR and a party of interest (as defined in Section 1903 [42 U.S.C. 1396b] (m)(4)(A) of the Social Security Act), including the following transactions:

11.15.1.1 Any sale or exchange or leasing of any property between the organization and such a party.

11.15.1.2 Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

11.15.1.3 Any lending of money or other extension of credit between the organization and such a party.

11.15.2 The CONTRACTOR shall report information concerning Significant Business Transactions as set forth in 42 CFR § 455.105 (2010, as amended).

11.15.2.1 The CONTRACTOR agrees to submit, within thirty-five (35) Calendar Days of a request from the Department, full and complete information about:

11.15.2.1.1 The ownership of any Subcontractor with whom the CONTRACTOR has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of this request; and

11.15.2.1.2 Any significant business transactions between the CONTRACTOR and any wholly owned supplier, or between the CONTRACTOR and any Subcontractor, during the five (5) year period ending on the date of this request.

11.15.3 For the purpose of this Contract, "Significant Business Transactions" means any business transaction or series of transactions during any of the fiscal year that exceed the twenty-five thousand dollars ($25,000) or five percent (5%) of the CONTRACTOR's total operating expenses.

11.16 Information on Persons Convicted of Crimes

11.16.1 The CONTRACTOR agrees to furnish to the Department or DHHS information concerning any person convicted of a criminal offense under a program relating to Medicare (Title XVIII) and Medicaid (Title XIX) as set forth in 42 CFR § 455.106 (2010, as amended).

Section 12. MATERIAL REVIEW REQUIREMENTS

12.1 General Marketing Requirements

This Section of this contract shall govern all communications, education and outreach, and marketing activities by the Contractor to a current or potential Medicaid Managed Care Member, not currently enrolled in a Medicaid Managed Care Health Plan. The requirements stated herein, apply to all written or oral communication, education and outreach materials and activities produced, distributed, or performed by or on behalf of the Contractor and shall meet the requirements set forth in 42 CFR § 438.102, 42 CFR § 438.104.

12.1.1 The Contractor shall use Member education and marketing tools to encourage each Member to be responsible for his or her own healthcare by becoming an informed and active participant in their care.

12.1.2 The Contractor shall ensure compliance with applicable state and federal marketing requirements, including monitoring and overseeing the activities of its subcontractors, and any other persons acting for, or on behalf of, the Contractor.

12.2 Guidelines for Communication, Outreach, and Marketing Materials and Activities

The Department's guidelines for appropriate communication, outreach, and marketing materials and activities shall be conducted in accordance with 42 CFR § 438.104(b)(1)(i) - (ii); 42 CFR § 438.104(b)(1)(iv) - (v); 42 CFR § 438.104(b)(2)(i) - (ii) and include consultation with the Medical Care Advisory Committee (MCAC) or an advisory committee with similar membership, as determined appropriate by the Department and in accordance with the Department's Managed Care Report Companion Guide.

The CONTRACTOR shall:

12.2.1 Be responsible for developing and implementing a written communication, education and outreach, and Marketing Plan designed to provide the Member, a Provider, or a Stakeholder with information about the CONTRACTOR's Health Plan.

12.2.2 Implement processes and procedures to assure the Department that it's communication, education and outreach, and marketing activities, including plans and materials, are accurate and does not mislead, confuse, or defraud potential Medicaid Managed Care Members, Providers, Stakeholders or the Department.

12.2.3 Distribute communication, education and outreach or marketing materials to its entire South Carolina Service Area.

12.2.4 Be subject to sanctions, including fines for violation of any of the listed communication, education and outreach, and marketing requirements listed in this contract. The Contractor may appeal these actions within thirty (30) Calendar Days in writing to the SCDHHS Office of Appeals and Hearings.

12.2.5 Conduct education, outreach or marketing activities in an orderly, non-disruptive manner and shall not interfere with the privacy of Members or the general community.

12.2.6 The Contractor may provide Department-approved marketing and educational materials for display and distribution by providers to Members. This includes printed material and audio/video presentations.

12.2.7 Provide to a Member, upon the Member's request, Department-approved marketing and educational materials.

12.2.8 Notify the Department of all sponsorships; however, no approval or submission of sponsorship material is required. The Contractor's sponsorships are not required to include the South Carolina Healthy Connections logo on the third-party host organization's materials, even if the Contractor's logo is on the materials.

12.2.9 Communication, education and outreach, and marketing materials include, but are not limited to the following:

a) Brochures

b) Fact sheets

c) Posters

d) Videos

e) Billboards

f) Banners

g) Signs

h) Commercials (radio and television ads/scripts)

i) Print ads (newspapers, magazines)

j) Event signage

k) Vehicle coverings (buses, vans, etc.)

l) Internet sites (corporate and advertising)

m) Social media sites (such as, but not limited to Facebook, Twitter, blogs)

n) Other advertising media as determined by the Department.

12.2.10 The Department and/or its designee shall only be responsible for distributing general Contractor Marketing Materials developed by the Contractor for inclusion in the Department's Enrollment package to be distributed to Members. The Department, at its sole discretion, shall determine which materials will be included.

12.3 Prohibited Statements and Claims

The Contractor shall:

12.3.1 Not include any assertion or statement (whether written or oral) that CMS, the federal or state government, or a similar entity endorses the CONTRACTOR.

12.3.2 Limit the reference to Benefits and/or services to those clearly specified under the terms of the contract, and available to Members for the full contract period, which has been approved by the Department.

12.3.2.1 The Contractor shall be prohibited from sharing information about the Contractor's other lines of business.

12.3.3 Limit reference to any Additional Benefits and/or services to those that have been prior approved by the Department or value-added services as approved by the Department.

12.3.4 The Contractor shall not misrepresent or provide fraudulent misleading information about the Medicaid Program, the Department and/or its policies.

12.3.5 The Contractor shall not use superlatives in logos/product taglines (e.g., "XYZ plan means the first in quality care" or "XYZ plan means the best in managed care"). Instead, the Contractor may use statements in its logos and in its product taglines such as, "Your health is our major concern," or "Quality care is our pledge to you".

12.3.6 The Contractor shall not use absolute superlatives (e.g., "the best," "highest ranked," "rated number 1"), unless they are substantiated with supporting data provided to the Agency as a part of the marketing review process.

12.3.7 Any claims stating that the Contractor is recommended or endorsed by any public or private agency or organization, or by any individual, shall receive prior written approval by the Department and must be certified in writing by the person or entity that is recommending or endorsing the Contractor.

12.4 Prohibited Activities

The Contractor shall:

12.4.1 Not seek to influence a member in conjunction with the sale or offering of any private insurance.

12.4.2 Not directly or indirectly engage in door-to-door, telephone, email, texting, or other cold-call marketing activities. Cold-Call Marketing activities are defined as any unsolicited personal contact by the Contractor with a potential Member for the purposes of Marketing.

12.4.3 Not distribute communication, education and outreach, or marketing materials without first obtaining the Department's approval.

12.4.4 Not assist a person in enrolling in a Health Plan or in the enrollment of add on services when conducting marketing activities.

12.4.5 Not engage in communication, marketing or education and outreach practices or distribute any materials that misrepresent, confuse, or defraud Members, Providers, stakeholders or the Department.

12.4.6 Not directly or indirectly approach a Member or potential Member for the purpose of marketing their health plans.

12.4.7 Not mention another South Carolina Medicaid Managed Care Health Plan by name and/or comparing their organization/Plan to another organization/Plan by name.

12.4.8 Not conduct marketing activities or distribute marketing materials at employee benefit meetings.

12.5 Nominal Gift Requirements

12.5.1 The Contractor is allowed to offer nominal "give-away items". The fair market value of the "give-away items" shall be no more than fifteen dollars ($15.00) and shall not be for alcohol, tobacco, or firearms.

12.5.2 Cash gifts of any amount, including contributions made on behalf of people attending an education and outreach or Marketing event, gift certificates or gift cards shall not be permitted to be given to Members or the general public, unless specifically given for Member incentives.

12.5.3 The Contractor shall receive prior written approval by the Department for items given for additional services, member incentives, provider incentives, or "give-away items" containing logos.

12.6 Marketing Materials and Activities Submission Requirements

The CONTRACTOR shall:

12.6.1 Follow the Department's requirements for Marketing Material submissions found in this Contract and the Department's Managed Care Report Companion Guide.

12.6.2 Provide written notice to the Department prior to conducting, sponsoring, or participating in Marketing activities.

12.6.3 Notification of all marketing activities must include the date, time, location, and details.

12.6.3.1 Submissions of intended marketing activities must be made to the Department no later than noon (12 PM Eastern Time), two (2) Business Days prior to the scheduled event. South Carolina State holidays are excluded from being counted as a Business Day.

12.7 Marketing Material Distribution and Publication Standards and Requirements

The CONTRACTOR shall:

12.7.1 Receive final approval from the Department prior to distribution of any Member, Provider or stakeholder communication, education and outreach and Marketing materials representing the Healthy Connections Medicaid Managed Care Program.

12.7.1.1 The Department agrees to respond to CONTRACTOR's request for approval of Marketing Materials within thirty (30) Calendar Days of submission and may approve, deny, or require modification of submitted materials within thirty (30) Calendar Days. If the Department fails to respond within thirty (30) Calendar Days, the CONTRACTOR may consider the request approved.

12.7.1.2 The Department reserves the right, in extraordinary circumstances, to extend the thirty (30) Calendar Day deadline. The Department shall notify the CONTRACTOR of the reason for the extension and expected date of decision.

12.7.2 Be allowed to directly and/or indirectly conduct education and outreach or Marketing activities in an office, clinic, hospital, or any other place where health care is delivered, with the written consent of the Provider. This also includes government facilities, such as local offices of the South Carolina Department of Health and Human Services, the Department of Social Services, the Department of Public Health, Head Start and public schools.

12.7.2.1 The use of government facilities for education and outreach or Marketing activities is only allowed with the written permission of the government entity involved. Any stipulations made by the provider or government entity must be followed (e.g., allowable dates, times, locations, etc.).

12.7.3 Only conduct marketing activities in health care setting common areas. Common areas where marketing activities are allowed include areas such as hospital or nursing facility cafeterias, community or recreational rooms, and conference rooms.

12.7.4 Not conduct marketing in areas where patients primarily intend to receive health care services or are waiting to receive health care services. These restricted areas generally include, but are not limited to, waiting rooms, exam rooms, and hospital patient rooms. The prohibition against conducting marketing activities in health care settings extends to activities planned in health care settings outside of normal business hours.

12.7.5 Conduct a quality check and ensure that all materials are consistent with State and federal requirements prior to submitting materials for review to the Department. Generally, the Department shall not review materials for typographical or grammatical errors, unless such errors render the material inaccurate or misleading.

12.7.6 The Department reserves the right to attend all Marketing activities/events. The Contractor shall secure the written permission of the business or event sponsor to conduct Marketing activities and make this document available to the Department if requested.

12.8 Marketing Plan Requirements

The CONTRACTOR shall:

12.8.1 Develop and implement a written Marketing/advertising plan to guide and control the CONTRACTOR’s Marketing activities.

12.8.2 Include detailed explanations of permitted activities, prohibited activities and appropriate and acceptable communication directly and/or indirectly with the Member.

12.8.3 Include details identifying the target audiences, Marketing strategies to be implemented, Marketing budget, and expected results.

12.8.4 Include details about the various events in which the CONTRACTOR expects to participate. 12.9 Member Information and Materials Requirements

The CONTRACTOR shall provide the following information to new Members: (1) a Member handbook, (2) an Identification Card (ID), (3) a Provider directory, and (4) Member education materials. Additional information about each individual requirement is listed below. The CONTRACTOR shall give each Member written notice of any significant change in the aforementioned materials at least thirty (30) Days prior to the intended effective date of the change. (See 42 CFR § 438.10(g)(4))

12.9.1 Member information may not be provided electronically by the CONTRACTOR unless all of the requirements are met in accordance with 42 CFR § 438.10(c)(6). The Contractor shall notify the Member that the information is available in paper form, without charge, upon request.

12.9.2 Member information will be considered to have been provided by the CONTRACTOR if the CONTRACTOR delivers such information in accordance with 42 CFR § 438.10(g)(3)(i)-(iv).

12.9.3 Have mechanisms in place to assist Members and potential Members in understanding the requirements and benefits of their plan (42 CFR 438.10(c)(7))

12.9.4 Definitions

The Contractor shall use the definitions listed in Appendix A and the descriptions as outlined in all applicable provider manuals for the following terms: Appeal; Co-Payment; Durable Medical Equipment; Emergency Medical Condition; Emergency Services; Grievance; Excluded Services; Health Insurance; Home and Community-Based Services; Hospice Services; Hospital Outpatient Care; Medical Necessity; Non-Participating Provider; Plan; Premium; Primary Care Provider; Prior Authorization; Provider; Provider Network; Single Preferred Drug List (sPDL); Special Health Care Needs; Specialist; and Urgent Care as required in 42 CFR § 438.10(c)(4)(i).

12.9.5 Member Handbook

The CONTRACTOR shall

12.9.5.1 Use the Department-developed model handbook 42 CFR § 438.10(c)(4)(ii).

12.9.5.2 Provide each Member a Member Handbook within thirty (30) Calendar Days of receiving notice of the Member's Enrollment with the CONTRACTOR. (42 CFR § 438.10(g)(1); 45 CFR § 147.200(a))

12.9.5.3 Publish a copy of the Member Handbook and document the changes on a change control log posted on its website.

12.9.5.4 Submit any subsequent changes to the Department for review and approval.

12.9.5.4.1 The Contractor shall provide each Member notice of any change in the information specified in the Member Handbook related to any of the

requirements of 42 CFR 438.10(g)(2) or other specific requirements of the Member Handbook outlined in this Contract at least thirty (30) Calendar days before the intended effective date of the change.

12.9.5.5 At a minimum, the Member handbook shall include all requirements as set forth in 42 CFR § 438.10(g)(2)(i)-(xvi) in addition to the following:

12.9.5.5.1 Table of contents,

12.9.5.5.2 A general description explaining how the CONTRACTOR's Health Plan operates,

12.9.5.5.3 Member's right to Disenroll,

12.9.5.5.4 Appropriate utilization of services including, Emergency Room for Non-Emergent conditions,

12.9.5.5.6 A description of the Medicaid card and CONTRACTOR's Member Identification (ID) Card and why both are necessary and how to use them,

12.9.5.5.7 The process and Procedures for obtaining Emergency Services, including use of the 9-1-1 telephone system or its local equivalent;

12.9.5.5.8 The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services

12.9.5.5.9 The post-stabilization care services rules set forth in 42 CFR § 422.113(c);

12.9.5.5.10 Information on how transportation is provided for any benefits carved out of this contract and provided by the state. [42 CFR § 438.10(g)(2)(i) - (ii)]

12.9.5.5.11 How and where to obtain counseling or referral services that the CONTRACTOR, or a provider under contract with the CONTRACTOR, does not cover because of moral or religious objections (42 CFR § 438.102(b)(1)(i)(B), 42 § CFR 438.10(g)(4));

12.9.5.5.12 All covered pharmacy product information for all CONTRACTOR members. The member handbook must contain the CONTRACTOR's full list of covered pharmacy products in addition to the Department's single PDL. The member handbook must also include the Procedures for accessing the Department's single preferred drug list.

12.9.5.5.12.1 The CONTRACTOR must make available in electronic form information in accordance with 42 CFR § 438.10(i) as well as any

step therapy or prior authorization requirements for non-managed drugs.

12.9.5.5.13 Member Grievance, Appeal and state fair hearing Procedures and time frames, as described in 42 CFR §§ 438.10(g)(2)(xi)(A)-(E), 438.228(b) and *Section 9* of this contract, to include the following:

12.9.5.5.13.1 Inform Members they must exhaust the Member's Appeal process prior to filing for a State fair hearing and inform the Members of the State fair hearing process and its Procedures.

12.9.5.5.13.2 The toll-free numbers that the member can use to file a Grievance or an Appeal by phone;

12.9.5.5.13.3 Members whose request for a Disenrollment for cause that is not approved by the Department or its designee, may request a fair hearing of the decision.

12.9.5.6 How to exercise advance Directives, as set forth in 42 CFR § 438.3(j) and 42 CFR § 489.102(a), which shall include:

12.9.5.6.1 Contractor's Policies related to advance directives, which shall meet the requirements of 42 CFR § 422.128 and 42 CFR § 489 SUBPART I;

12.9.5.6.2 Any limitations the Contractor places on the implementation of advance directives as a matter of conscience;

12.9.5.6.3 The member's rights under state law, including the right to accept or refuse medical, surgical, or Behavioral Health treatment and the right to formulate advance directives.

12.9.5.6.4 Information about where a member can seek assistance in executing an advance directive and to whom copies should be given.

12.9.5.6.5 Information about complaints concerning non-compliance with the advance directive requirements may be filed with the State survey and certification agency.

12.9.5.6.6 Any changes in law shall be reflected in the member handbook as soon as possible, but no later than ninety (90) Calendar Days after the effective date of the change.

12.9.5.7 Information to call the Medicaid customer service unit toll-free hotline or visit a local Medicaid eligibility office to report changes in family size, living arrangements, county of residence, or mailing address

12.9.5.8 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show".

12.9.5.9 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;

12.9.5.10 Information about the requirement that a member shall notify the Contractor immediately of any worker's compensation Claim, a pending personal injury or medical malpractice lawsuit, or if the member has been involved in an auto accident;

12.9.5.11 Reporting requirements for the member who has or obtains another health insurance policy, including employer-sponsored insurance. Such situations shall be reported to the CONTRACTOR;

12.9.5.12 Information on the Member's right to a second opinion at no cost and how to obtain it;

12.9.5.13 Any Additional Services provided by the CONTRACTOR;

12.9.5.14 The date of the last revision;

12.9.5.15 Additional information that is available upon request, including the following:

12.9.5.15.1 Information on the structure and operation of the CONTRACTOR;

12.9.5.15.2 Physician incentive plans (42 CFR § 438.10(f)(3); 42 CFR § 438.3(i)); and

12.9.5.15.3 Service utilization Policies.

12.9.5.16 Describe the transition of care policies for current and potential Members as per 42 CFR § 438.62(b)(3).

12.9.5.17 Inform the Member that each family member has the right to choose his/her own primary care provider. The handbook may explain the advantages of selecting the same PCP for all family members, as appropriate.

12.9.5.18 The Member Handbook shall conspicuously state the following in bold print: "THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN THE CONTRACTOR AND THE MEMBER."

12.9.5.19 Notify each Member, at least once each calendar year, of their right to request a Member handbook or Provider directory.

12.9.6 Member Identification (ID) Card

The CONTRACTOR shall:

12.9.6.1 Issue a Member Identification Card (ID) for each Member no later than the fifteenth (15th) business day following the Contractor's receipt of the Member's eligibility information on the daily files provided by the Department.

12.9.6.2 Use the Medicaid Member's identification number issued by the Department.

12.9.6.3 Ensure Member ID cards contain the following information:

12.9.6.3.1 CONTRACTOR name and address

12.9.6.3.2 Primary care Provider or practice name

12.9.6.3.3 Medicaid Managed Care Member full name and Medicaid identification number

12.9.6.3.4 Expiration date (optional)

12.9.6.3.5 Toll-free telephone numbers, including the number a Medicaid Managed Care Member may use in urgent or emergency situations or to obtain any other information

12.9.6.3.6 SC Healthy Connections logo, in adherence with SCDHHS Healthy Connections style guide

12.9.6.4 Reissue the Member ID card within fourteen (14) Calendar Days after notice by a member of a lost card, a change in the member's PCP, or for any other reason that results in a change to the information on the card.

12.9.6.5 Ensure the holder of the Member identification card Member ID card issued by the CONTRACTOR is a Member or guardian of the Member.

12.9.6.6 Immediately report to the Department any incident of a Member permitting the use of his or her identification card by any other person.

12.9.6.7 Establish appropriate mechanisms, Procedures and Policies to identify its Members to Providers during the period when the Member has not received an ID card from the Contractor.

12.9.6.8 Ensure that its In Network Providers can identify Members, in a manner that will not result in discrimination against the Members, to provide or coordinate the provision of all Core Benefits and/or Additional Services and out-of-network Services.

12.9.7 Provider Directory

The CONTRACTOR shall:

12.9.7.1 Make available a Provider directory to the Member, in electronic or paper form, upon request, in accordance with 42 CFR438.10(h)(1)-(2), to also include the following information on the Contractor's provider network:

12.9.7.1.1 Providers name as well as any group affiliation, street address(es), office hours, age groups, telephone numbers, web site URL's as appropriate, specialty as appropriate, whether the Provider will accept new Members, the Providers ability to accommodate individuals with physical disabilities and the Providers cultural and linguistic abilities. Cultural and

linguistic ability must include information on the non-English languages spoken by current In Network Providers. (42 CFR § 438.10(h)(1)(i) - (viii); 42 CFR § 438.10(h)(2))

12.9.7.2 The Contractor shall make the provider directories available on the Contractor's website in a machine-readable file and format as specified by the Secretary, per 42 CFR § 438.10(h)(4).

12.9.7.3 Include, at a minimum, information about the following Providers: (1) Primary Care Providers (PCPs), (2) Specialty and Behavioral Health Providers, (3) Pharmacies, (4) Hospitals, (5) Certified Nurse Midwives, (6) Licensed Midwives, (7) Long Term Support Service (LTSS) Providers and (7) Ancillary Providers. (42 CFR § 438.10(h)(1)(i) - (viii); 42 CFR § 438.10(h)(2))

12.9.7.4 The Contractor shall provide the Member the provider network information in accordance with [42 CFR § 438.10(h)(3)(i)(A) – (B), 42 CFR § 438.10(h)(3)(ii)] to include:

12.9.7.4.1 Information included in a paper Provider directory must be updated at least: (1) monthly, if the CONTRACTOR does not have a mobile-enabled electronic provider directory; or (2) at least quarterly if the CONTRACTOR does have a mobile-enabled provider directory.

12.9.7.4.2 Electronic Provider directories must be updated no later than thirty (30) Calendar Days after the CONTRACTOR receives updated Provider information. (42 CFR § 438.10(h)(3)(i)(A) – (B), 42 CFR § 438.10(h)(3)(ii))

12.9.7.5 List Providers by name in alphabetical order, showing the Provider's specialty.

12.9.7.6 List Providers by specialty, in alphabetical order.

12.9.7.7 Include a statement that some Providers may choose not to perform certain services based on religious or moral beliefs (Section 1932(b)(3)(B) of the Social Security Act).

12.9.7.8 Have Procedures to inform potential Members and existing Members, upon request, of any changes to the Provider network.

12.9.7.9 Provide up-to-date information about any Provider access restrictions.

12.9.7.10 An explanation to all potential Members that an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member’s needs.

12.10 Member Education

The Contractor shall provide educational activities and materials directed at Members that increases awareness, and favorably influences the attitudes and knowledge relating to the improvement of health on a personal or community basis.

The CONTRACTOR shall:

12.10.1 Through the initial mailing to all Members, educate the Member regarding the appropriate utilization of Medicaid services. Verbal education may complement but not replace written materials.

12.10.2 Include information and materials that inform the Member on the Contractor's Policies, Procedures, requirements, and practices including member rights and responsibilities.

12.10.3 Provide education no later than fourteen (14) Calendar Days from the Contractor's receipt of Enrollment data from the Department, or its designee, and as needed thereafter.

12.10.4 Identify and educate Members who access the healthcare system inappropriately and provide continuing education as needed.

12.10.5 Based on the most recent county census data, ensure that where at least five (5) percent or more of the county's resident population is non-English speaking and speaks a specific foreign language, materials will be made available in that specific language to assure a reasonable chance for all Members to understand how to access the Contractor and use services appropriately.

12.10.6 Coordinate with the Department or its designee on Member education activities to meet the health care educational needs of the Members.

12.10.7 Develop and implement an education and outreach program with the primary objective to increase the number of members accessing Medicaid benefits and receiving preventative health care services.

12.10.8 Conduct regionally located and regularly scheduled outreach activities to inform members about the availability of services, to decrease emergency department use of non-traumatic conditions, and to significantly increase the number of children receiving services. The results of the outreach activities should be measurable and support the overall goal of increasing awareness of and/or utilization of services.

12.10.9 The Department and/or its designee shall only be responsible for distributing general education and outreach materials developed by the Contractor for inclusion in the Department Enrollment package to be distributed to Members, and at its sole discretion, will determine which materials shall be included.

12.11 Member Education Events

12.11.1 The Contractor shall conduct education and outreach activities at events and locations including, but not limited to, health fairs, health screenings, schools, churches, housing authority meetings, private businesses, and other community events.

12.11.1.1 Member educational events must be held in a public venue. The Contractor shall ensure that events are not held at the home of an individual or as a one-on-one appointment.

12.11.2 The Contractor may distribute permissible public event materials, nominal gifts, or display promotional materials such as banners, posters or other displays with the Contractor name, logo, product tagline, telephone contact number, and/or website at Member educational events.

12.11.2.1 The Contractor shall ensure that nominal gifts are free of benefit information and consistent with the requirements of nominal gifts specified in this Contract.

12.11.3 The Contractor may be a participating or primary sponsor of a community event.

12.11.5 The Department shall reserve the right to attend all education and outreach activities and events.

12.11.6 The Contractor shall not do any of the following regarding Member Educational Events:

12.11.6.1 Conduct marketing activities;

12.11.6.2 Distribute marketing materials;

12.11.6.3 Advertise an event to anyone other than Members;

And

12.11.6.4 Conduct a marketing event immediately following a Member educational event in the same general location.

12.12 Submission of Education and Event Materials

The Contractor shall:

12.12.1 Submit all education and outreach events/activities as prescribed by the Department and detailed in the Managed Care Report Companion Guide.

12.12.2 Ensure submissions are made to the Department no later than noon (12 PM Eastern Time), two (2) Business Days prior to the scheduled event. South Carolina State holidays and Federal holidays are excluded from being counted as a Business Day.

12.12.3 Ensure notification of all events or activities include the date, time, location, and details.

12.12.4 Secure the written permission of the business or event sponsor to conduct education and outreach activities and make this document available to the Department, if requested.

12.13 Member Communication

The following guidelines apply to written materials and oral communication with Medicaid Managed Care Members. The guidelines will apply to the CONTRACTOR and any Subcontractor.

12.13.1 Written Materials Guidelines

The CONTRACTOR shall:

12.13.1.1 Comply with 42 CFR § 438.10(c) as outlined in this Section of the contract, as it relates to all federal and state guidelines, as well as industry best practices,

regarding written member materials, regardless of the means of distribution (printed, web, advertising, direct mail, etc.)

12.13.1.2 Create written materials for potential Members and Members in a style and reading level that will utilize easily understood language and format to accommodate the reading skills of those Members. (42 CFR § 438.10(d)(6)(i))

12.13.1.3 In general, ensure that the writing shall be written at a grade level no higher than the sixth (6th) grade (6.9 on the reading scale) as determined by any one of the indices below, or deemed as appropriate by the Department, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy:

12.13.1.3.1 Flesch – Kincaid;

12.13.1.3.2 Fry Readability Index;

12.13.1.3.3 PROSE The Readability Analyst (software developed by Educational Activities, Inc.);

12.13.1.3.4 Gunning FOG Index;

And/Or,

12.13.1.3.5 McLaughlin SMOG Index

12.13.1.4 Ensure all written materials are clearly legible with a font size no smaller than 12 point as defined in 42 CFR § 438.10(d)(6), with the exception of Member ID cards, and unless otherwise approved by Department.

12.13.1.5 Ensure the CONTRACTOR's name, mailing address (and physical location, if different) and toll-free number is prominently displayed on the cover of all multi-page Marketing materials.

12.13.1.6 Not use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet or other communication, or a broadcast, telecast, or other production, alone or with other words, letters, symbols or emblems for the words "Medicaid," or "Department of Health and Human Services," except as permitted by the Department when prior written approval is obtained. Specific written authorization from the Department is required to reproduce, reprint, or distribute any Department form, application, or publication for a fee. A disclaimer that accompanies the inappropriate use of program or Department terms does not provide a defense. Each piece of mail or information constitutes a violation.

12.13.1.7 All print and/or web-based materials or communications to Members and potential Members that include the CONTRACTOR's logo must also contain the South Carolina Healthy Connections Medicaid logo. The Contractor and SC Healthy Connections Medicaid logos must be proportional in size and location as approved by the Department.

12.13.1.8 The written information shall be available in each Prevalent Non-English Language. Foreign language versions of Materials are required if the population speaking a particular foreign (non-English) language in the county is greater than five percent (5%). These materials must be approved, in writing, by the Department. Affidavits of accuracy and reading level compliance by a professional translation service must accompany all foreign language translations and be submitted with the approval request.

12.13.1.9 Include with the submission of Member materials, details identifying the target audiences, communication and outreach strategies to be implemented, budget, and expected results.

12.13.2 Member Newsletter

12.13.2.1 The Contractor must publish a newsletter for Members at least twice per year. The newsletter will focus on topics of interest to Members and must adhere to the requirements for Written Member Materials as outlined in this section of the contract.

12.13.2.2 The Contractor must provide a copy of all newsletters to the State for approval prior to publication/distribution.

12.13.2.3 The Contractor shall ensure that Member Newsletters are published on the Contractor's website in a timely manner.

12.14 Online Member Materials

12.14.1 The Contractor may provide a link to smartphone applications for Member use that will take Members directly to existing, Department-approved materials on the Contractor's website.

12.14.2 The Contractor shall identify and educate Members who access the Contractor's online system inappropriately and provide continuing education, as needed.

12.14.3 All online member materials shall be submitted for review and approval by the Department within seven (7) Business days of a substantial change to the Contractor's services or other relevant Member material information.

12.14.4 Contractor Website

In order for the Contractor to provide quality customer service to Medicaid consumers, Department stakeholders, and other entities, information must be accessible without undue burden regarding program benefits, eligibility, policy, processes, reports, and the ability to communicate readily with the Department.

The Contractor's website for Healthy Connections Medicaid-related information shall act as a single gateway tool that will provide general and program specific information as well as links to other programs, applications and related agencies and resources. The website shall have both secure and non-secure areas.

The Contractor's website shall:

12.14.4.1 Provide online training and assistance modules for providers to access as needed. These resources shall include online Provider Manuals, virtual training for South Carolina Medicaid providers, and other online services as defined by the Department.

12.14.4.2 The website and other system components as required by the Department shall be available twenty-four (24) hours per day, seven (7) days per week (24/7), 365 days a year except with scheduled downtime.

12.14.4.3 The Contractor shall notify the Department in writing thirty (30) calendar days prior to scheduled system downtime that will affect operations.

12.14.4.3.1 The Contractor shall provide the reason for the downtime and when the system is expected to be unavailable. In the event of unscheduled downtime, the Contractor shall immediately notify the Department of the downtime, provide a written action plan to resume system activity, and provide a time when the system is expected to be available.

12.14.4.4 The website and other system components must provide a user interface that complies with recognized usability standards (e.g., the Americans with Disabilities Act (ADA), the Older Americans Act, the Rehabilitation Act Section 508 Subpart B Section 1194.21, etc.).

12.14.4.5 Any changes to the Contractor's website shall be submitted to the Department for approval through the same processes as outlined in this Section of the Contract and the Managed Care Report Companion Guide.

12.14.5 Social Media Activities

12.14.5.1 The Contractor is permitted to use social media.

12.14.5.2 All social media sites must receive prior written approval from the Department before launching.

12.14.5.3 All new content for social media messages, as defined by 42 CFR § 438.104, must be pre-approved by the Department. If the messages were already approved by the Department on other communication or education and outreach materials, they may be used for social media and do not require additional approval.

12.14.5.3.1 Health and wellness messages and third-party educational materials do not need approval by the Department.

12.14.5.4 Once the Contractor submits the proper written notification for conducting, sponsoring, or participating in education and outreach activities and events, the Contractor may post about the activity/event before, during, and after the activity/event but must adhere to the CFR and Department requirements in their messaging.

12.14.5.5 Standard template responses to social media inquiries are considered scripts and must receive approval from the Department.

12.14.5.6 If the Contractor's parent corporation has a social media presence, any messaging to promote SC-specific Medicaid events or messages are subject to Department approval.

12.14.5.7 The Contractor shall include the following disclaimer language on all social media sites: "The views and opinions expressed on this site are those of [INSERT Contractor NAME HERE] and do not necessarily reflect the official Policy or position of the South Carolina Department of Health and Human Services, nor any other agency of the State of South Carolina or the U.S. government."

12.14.5.8 All social media requests and submissions must be submitted via the Contractor SharePoint Site. The Department shall respond to these requests within the timeframe as described in this section of the Contract.

12.15 Translation Services and Alternative Formats

The CONTRACTOR shall:

12.15.1 Develop written Policies and Procedures for providing language interpreter and translation services to any Member who needs such services, including but not limited to: (a) Members with limited English proficiency, and (b) Members who are hearing impaired in accordance with 42 CFR § 438.10(d)(3).

12.15.2 Provide interpreter and translation services free of charge to Members.

12.15.3 Ensure interpreter services are available, and Members have been notified of the availability of such services in accordance with 42 CFR § 438.10(d)(5);this includes oral interpretation and the use of auxiliary aids such TTY/TDY and American sign language. All oral interpretation requirements apply to all non-English languages. (42 CFR § 438.10(d)(4))

12.15.4 Make all written materials available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the potential Member's or Member's special needs with disabilities or limited English reading proficiency. [42 CFR § 438.10(d)(6)(iii)]

12.15.5 Ensure all written materials that are critical to obtaining services, defined as Provider directories, Member handbooks, Appeal and Grievance notices, and denial and termination notices, must be available in the prevalent non- English languages in its particular Service Area.

12.15.6 All written materials that are critical to obtaining services shall comply with 42 CFR § 438.10(d)(3) and include taglines in the prevalent non-English languages in the state, shall be written in a conspicuously visible font size. The Contractor's written materials shall:

12.15.6.1 Be available in alternative formats upon request of the member at no cost to the member.

12.15.6.2 Explain the availability of written translation or oral interpretation to understand the information provided.

12.15.6.3 Provide information on how to request auxiliary aids and services.

12.15.6.4 Provide the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of the Contractor's member/customer service unit.

12.15.7 Notify all Members and, upon request, potential Members that information is available in alternative formats and how to access those formats.

12.15.7.1 All written materials for potential Enrollees must include taglines in the prevalent non-English languages in the State based on the most recent State census data, in a font size no smaller than 12 point, explaining the availability of written translations or oral interpretation to understand the information as required by 42 CFR §438.10(d)(3).

12.15.7.2 Provide written information available in the prevalent non- English languages identified by the Department in particular Service Areas.

12.15.8 The availability and accessibility of translation services should not be predicated upon the non-availability of a friend or family member who is bilingual. Members may elect to use a friend or relative for this purpose, but they must not be encouraged to substitute a friend or relative for a translation service.

12.16 Provider to Member Communication

In accordance with Section 1932(b)(3)(A) of the Act and 42 CFR § 438.102(a)(1)(i) - (iv), the CONTRACTOR shall:

12.16.1 Not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a Member who is their patient regarding:

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

12.16.1.2 Any information the Enrollee needs to decide among all relevant treatment options.

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

12.16.1.4 The Enrollee's right to participate in decisions regarding health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Section 13. REPORTING REQUIREMENTS

13.1 General Requirements

The CONTRACTOR:

13.1.1 Must maintain health information systems that collect, analyze, integrate, and report data for the PCMH, EQI and HEDIS requirements and attest to their accuracy as required by 42 CFR § 438.606. Health information systems must provide information on areas including, but not limited to, utilization, Claims, Grievances, Appeals and Disenrollments.

13.1.2 Is responsible for complying with all of the reporting requirements established by the Department, including the standards outlined in the Managed Care Managed Care Report Companion Guide.

13.1.3 Must connect using TCP/IP protocol to a specific port using Connect Direct software after signing a trading partner agreement as required by the Department's information technology area.

13.1.4 Shall provide the Department and any of its designees with copies of agreed upon reports generated by the CONTRACTOR concerning Members and any additional reports as requested in regard to performance under this contract.

13.1.5 Must comply with the appropriate reporting formats, instructions, submission timetables, and technical assistance when required. The Department may, at its discretion, change the content, format, or frequency of reports.

13.1.6 Must supply a copy of the South Carolina Department of Insurance or National Association of Insurance Commissioner (SCDOI/NAIC) quarterly and annual filings within five (5) working days after the SCDOI/NAIC due date plus any extensions.

13.1.7 May be instructed to submit additional reports, both ad hoc and recurring. If the Department requests any revisions to the reports already submitted, the CONTRACTOR shall make the changes and re-submit the reports, according to the time period and format required by the Department. All reports shall be submitted in accordance with the schedule outlined in *Exhibit 3*.

Exhibit 3. Reporting Schedule by Deliverable and Submission Due Date

DELIVERABLE	SUBMISSION DUE DATE
Daily Reports	Within three (3) Business Days
Weekly Reports	Within three (3) Business Days
Monthly Reports	Within fifteen (15) Calendar Days
Quarterly Reports	Within thirty (30) Calendar Days, Excluding FQHC/RHC quarterly reporting requirements
Annual Reports	Within ninety (90) Calendar Days after the end of the year.

Ad Hoc/Additional Reports	Within three (3) Business Days from the date of request unless otherwise specified by the Department.

13.1.8 Shall submit an attestation in the event there are no instances to report stating that there is nothing to report.

13.1.9 Shall submit all reports electronically and in the manner and format prescribed by the Department and shall ensure that all reports are complete, accurate and submitted securely.

13.1.9.1 The CONTRACTOR, unless granted an exception by the Department, shall be subject to liquidated damages as specified in *Section 18* of this Contract for reports determined to be late, incorrect, incomplete or deficient, or not submitted in the manner and format prescribed by the Department until all deficiencies have been corrected.

13.1.9.2 When applicable, the required reports must be comparable to the Encounter data submitted to the Department for the same time frames.

13.1.10 Confidentiality of Information

The CONTRACTOR shall:

13.1.10.1 Clearly identify information the CONTRACTOR considers proprietary at the time of submission.

13.1.10.2 Not withhold information designated as confidential or proprietary.

13.1.10.3 Except as required by law, require the Department to receive prior written consent to disclose CONTRACTOR information designated as confidential.

13.1.10.4 Provide the Department with a detailed legal analysis of its belief that Department requested information of the CONTRACTOR is confidential and may not be disclosed to Third Parties. The analysis must be submitted to the Department within the timeframe designated by the Department, setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

13.1.10.5 Be responsible for all costs associated with the nondisclosure, including but not limited to, legal fees and costs for instances when the Department withholds information from a Third Party as a result of the CONTRACTOR's statement.

Section 14. ENCOUNTER DATA, REPORTING AND SUBMISSION REQUIREMENTS

14.1 General Data Requirements

The CONTRACTOR is required to exchange data with the Department relating to the information requirements of this contract and as required to support the data elements to be provided to the Department in accordance with 42 CFR § 438.242 and as specified in this contract.

The CONTRACTOR shall:

14.1.1 Submit all member Encounter data that the Department is required to report to CMS under 42 CFR § 438.818. The Contractor shall:

14.1.1.1 Submit data on the basis of which the Department certifies the actuarial soundness of capitation rates to the Contractor, including base data that is generated by the Contractor. (See 42 CFR 438.604(a)(2))

14.1.1.2 Submit data on the basis of which the Department determines that the Contractor has made adequate provision against the risk of insolvency. (See 42 CFR 438.604(a)(4))

14.1.2 Ensure all data exchanged must be in the formats and manner prescribed by the Department, which include those required/covered by the Health Insurance Portability and Accountability Act (HIPAA) and in 42 CFR § 438.818.

14.1.3 Follow the detailed reporting formats found in the HIPAA transaction companion guides, trading partner agreements, and any of the Department's Policies and guides available on the Department's website.

14.1.4 Follow all Procedures, Policies, rules, or statutes in effect during the term of this contract for reporting data to and exchanging data with the Department.

14.1.4.1 If any of these Procedures, Policies, rules, regulations, or statutes are hereinafter changed, both parties agree to conform to these changes following notification by the Department.

14.1.5 Be responsible for complying with all of the reporting requirements established by Department and shall provide access to all collected data to the Department, its designees and to CMS upon request as required by 42 CFR § 438.242(b)(4).

14.1.6 Certify all submitted data, documents, and reports to be accurate, complete, and truthful, and must submit any other data, documentation, or information relating to the performance of the Contractor's obligations as required by the Department or Secretary as required by 42 CFR § 438.606 and 42 CFR 438.604(b).

14.1.6.1 The data that must be certified include, but are not limited to, all documents specified by the State, Enrollment information, Encounter data, and other information contained in contracts, proposals.

14.1.6.2 The certification must attest, based on best knowledge, information, and belief the data, documentation, and information specified in 42 CFR § 438.604 is accurate, complete, and truthful.

14.1.6.3 The CONTRACTOR must submit the certification monthly or concurrently with the certified data and documents. Please refer to the Managed Care Report Companion Guide for specific requirements.

14.1.6.4 This certification shall be made by one of the following:

14.1.6.4.1 The CONTRACTOR's Chief Executive Officer (CEO),

14.1.6.4.2 The CONTRACTOR's Chief Financial Officer (CFO),

or

14.1.6.4.3 An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CFO or CEO bears ultimately responsibility for the certification.

14.1.6.5 The certification shall be submitted concurrently with the certified data.

14.1.7 Be responsible for any incorrect data, delayed submission, or payment (to the CONTRACTOR or its Subcontractors), and/or penalty applied due to any error, omission, deletion, or erroneous insert caused by CONTRACTOR-submitted data.

14.1.7.1 The Department shall not accept any data that does not meet the standards required by the Department.

14.1.7.2 The CONTRACTOR further agrees to indemnify and hold harmless the State of South Carolina and the Department from any and all Claims or liabilities, including but not limited to consequential damages, reimbursements or erroneous billings and reimbursements of attorney fees incurred as a consequence of any error, omission, deletion or erroneous insert caused by the CONTRACTOR in the submitted input data.

14.1.8 Be responsible for any incorrect or delayed payment to the CONTRACTOR's Providers resulting from such error, omission, deletion, or erroneous input data caused by the CONTRACTOR in the submission of Medicaid Claims. Neither the State of South Carolina nor the Department is responsible for such errors and delayed payments resulting from the errors.

14.1.9 Be responsible for identifying any inconsistencies immediately upon receipt of data from the Department.

14.1.10 If any unreported inconsistencies are subsequently discovered, the CONTRACTOR shall be responsible for the necessary adjustments to correct its records at its own expense.

14.2 Member Data

The CONTRACTOR shall:

14.2.1 Accept from the Department original evidence of eligibility and Enrollment in the Department prescribed electronic data exchange formats.

14.2.2 Maintain sufficient patient Encounter data to identify the Physician who delivered services to patients in accordance with 1903(m)(2)(A)(xi) of the Social Security Act.

14.3 Claims Data

The CONTRACTOR shall:

14.3.1 Ensure the CONTRACTOR's systems are capable of collecting, storing, and producing information for the purposes of financial, medical, and operational management and comply with Section 6504(a) of the ACA.

14.3.2 Develop and maintain HIPAA compliant Claims and Encounter processing and payment systems capable of processing, cost avoiding and paying Claims in accordance with applicable South Carolina and federal rules.

14.3.3 Ensure the CONTRACTOR's systems are adaptable to updates to support future Department Claims related policy requirements specified by the Department on a timely basis as needed.

14.3.4 Ensure the CONTRACTOR'S system is capable of meeting 42 CFR § 438.242(b)(5) and 42 CFR § 457.1233(d)(2) within one business day of processing or receiving the information for the following data requirements:

14.3.4.1 Data concerning adjudicated Claims, including Claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and Provider remittances and Member cost-sharing pertaining to such claims;

14.3.4.2 Encounter data, including Encounter data from any network Providers the Contractor is compensating on the basis of capitation payments and adjudicated Claims and Encounter data from any subcontractors;

14.3.4.3 Clinical data, including laboratory results, if the Contractor maintains any such data;

And

14.3.4.4 Information about covered outpatient drugs and updates to such information, including, where applicable, single Preferred Drug List information.

14.4 Electronic Transactions

The CONTRACTOR shall:

14.4.1 Allow Providers to check Member Enrollment in CONTRACTORs plan across a HIPAA compliant web-based portal.

14.4.2 Allow Providers to submit Claims for Member services across a HIPAA compliant web-based Claims submission portal and have the capability to accept electronic Claim attachments.

14.4.3 Be able to make Claims payments via electronic funds transfer.

14.5 Submission of Test Encounter Data

The CONTRACTOR must:

14.5.1 Successfully exchange Encounter data for all applicable form types with the Department upon the commencement of the Contract.

14.5.2 The Contractor shall comply with the following test requirements:

14.5.2.1 Provide an Encounter testing plan to the Department thirty (30) days in advance of any requested Encounter testing.

14.5.2.1.1 The Department and/or its designee will review all Encounter testing plans and provide the CONTRACTOR with an Encounter testing begin date.

14.5.2.1.2 The test plan shall include the following details:

14.5.2.1.2.1 Test Strategy: The Contractor's detailed plan outlining how they will undertake testing with the Department;

14.5.2.1.2.2 Testing Scope: The testing must include information on both what is in and out of scope for the testing plan;

14.5.2.1.2.3 Test Approach: The testing approach must include the types of Encounters being tested, the scenarios the Contractor desires to test, milestones for the project, and the desired turnaround times for data submitted in the testing environment.

14.5.2.1.2.4 Testing risks and assumptions;

14.5.2.1.2.5 Deliverables and dependencies;

14.5.2.1.2.6 Testing entry-exit criteria;

And

14.5.2.1.2.7 Templates and references.

14.5.2.2 Be responsible for passing a test process for each of the HIPAA transaction types prior to submitting production Encounter data.

14.5.2.3 Pass the testing phase for all Encounter Claim type submissions prior to the project plan implementation date.

14.5.2.4 Not be permitted to provide services under this contract, nor shall the CONTRACTOR receive Capitation Payment, until it has passed the testing and production submission of Encounter data.

14.5.3 Submitter Identification Number (ID)

The CONTRACTOR shall:

14.5.3.1 Make an application to obtain a submitter identification number, according to the instructions listed in the Department's companion guide(s).

14.5.4 Test File Format(s)

The CONTRACTOR shall:

14.5.4.1 Utilize production Encounter data, systems, tables, and programs when processing Encounter test files.

14.5.4.2 Submit error-free production data once testing has been approved for all of the Encounter Claims types.

14.6 Encounter Data

The CONTRACTOR:

14.6.1 Must incorporate HIPAA security, privacy, and transaction standards and be submitted in the American National Standards Institute (ANSI) ASC X12N 837 format or any successor format in this record. (42 CFR § 438.242(c)(4))

14.6.2 Must submit Encounters in the format prescribed by the Department.

14.6.2.1 The CONTRACTOR shall submit Encounter data according to standards and formats as defined by the Department, complying with standard code sets, and maintaining integrity with all reference data sources including Provider and Member data. Required standard transactions include:

14.6.2.1.1 ANSI ASC X12N 837P health care Claims (837P) transaction for Professional Claims and/or Encounters.

14.6.2.1.2 ANSI ASC X12N 837I health care Claims (837I) transaction for Institutional Claims and/or Encounters.

14.6.2.1.3 National Council for Prescription Drug Program Claims (NCPDP) transaction for prescription drug Claims.

14.6.2.1.4 277CA – Claim acknowledgement receipt transaction.

14.6.2.1.5 999- Acknowledgement of Claim transaction receipt.

14.6.2.1.6 All required file transfer protocols and associated batch jobs.

14.6.3 Must comply with information for submitting HIPAA compliant Encounters identified in the Managed Care Report Companion guide and the Department's companion guides. (See 42 CFR § 438.242(c)(2))

14.6.4 Must submit one hundred percent (100%) of its Encounter/Claim data to Department for every service rendered to a member that resulted in a paid Claim. (42 CFR § 438.242(c)(3))

14.6.4.1 In the event that the Contractor splits an Encounter, the Contractor shall utilize an approach that does not materially alter the original Claim submitted by the Provider.

14.6.5 Submitted and accepted Encounters must be at least ninety-seven percent (97%) complete both monthly and quarterly in total.

14.6.5.1 Submitted and accepted institutional Encounters (837I) must be at least ninety-seven percent (97%) complete monthly and quarterly.

14.6.5.2 Submitted and accepted professional Encounters (837P) must be at least ninety-seven percent (97%) complete monthly and quarterly.

14.6.5.3 Submitted and accepted pharmacy Encounters (NCPDPD) must be at least ninety-seven percent (97%) complete monthly and quarterly.

14.6.6 Measurements of completeness will be performed both monthly and quarterly utilizing reported total paid amounts from the Contractor's financial reporting and evaluating it against total Department accepted encounters.

14.6.7 The Contractor shall have until the twenty-fifth (25th) day following the month in which a claim was paid to submit an acceptable encounter to the Department.

14.6.8 Claims for services eligible for processing by the CONTRACTOR where no financial liability was incurred, including services provided during prior period coverage (i.e., zero paid Claims) must also be included in submitted and accepted Encounter data. The Department may also require submission of rejected and denied claims.

14.6.9 Any item(s) or service(s) provided through Medicaid under a prepaid, capitated, or any other Risk basis payment methodology must be submitted to the Department, including non-Fee-For-Service Medicaid payments based with Quality such as bundled payments, partial capitation, fully capitated payments, and/or global rates designed to promote Alternative Payment Methodologies.

14.6.10 Shall adhere to federal and/or Department payment rules in the definition and treatment of certain data elements, e.g., units of service that are standard fields in the Encounter data submissions and will be treated similarly by the Department across all CONTRACTORs.

14.6.11 Shall report the national provider identifier (NPI) for all of its Providers (participating or Non-Participating), who are covered entities or health care Providers and eligible to receive an NPI, on all Claims and Encounter data submitted to the Department. The CONTRACTOR shall work with Providers to obtain their NPI.

14.6.12 Shall collect data on Member and Provider characteristics as specified by the Department and on all services furnished to Members through an Encounter data system or other methods as may be specified by the Department under 42 CFR §§ 438.242(b)(2), and 438.242(c)(1).

14.6.12.1 In accordance 42 CFR § 438.242(b)(3)(iii), the CONTRACTOR shall ensure data received from Providers is accurate and complete by collecting data from Providers in standardized formats, that is feasible and appropriate, including secure information exchanges and technologies utilized for Medicaid quality improvement and care coordination efforts.

14.6.13 Must use standardized conventions for Provider names, addresses, Provider type, and other Provider descriptive information, as specified by the Department, to ensure Provider data comparability across all CONTRACTORs.

14.6.13.1 Upon request by the Department, the CONTRACTOR shall provide additional information to correctly identify Providers.

14.6.14 Shall comply with industry-accepted Clean Claim standards for all Encounter data, including submission of complete and accurate data for all fields required on standard billing forms or electronic Claim formats including encounter allowed and paid amounts, to support proper adjudication.

14.6.14.1 All Encounter data submissions will be subjected to systematic data quality edits and audits on submission to verify not only the data content but also the accuracy of Claims processing.

14.6.14.2 Any individual record submission that contains fatal errors that prevent processing or that does not satisfy defined threshold error rates will be rejected and returned to the CONTRACTOR for immediate correction.

14.6.14.2.1 Due to the need for timely data and to maintain integrity of processing sequence, the CONTRACTOR shall address any issues that prevent processing of an Encounter in accordance with Procedures specified in Managed Care Report Companion Guide and applicable Encounter Companion Guides.

14.6.15 Shall be required to submit all data relevant to the adjudication and payment of Claims in sufficient detail, as defined by the Department, to support comprehensive financial reporting and utilization analysis.

14.6.16 Is not responsible for submitting contested Claims or Encounters until final adjudication has been determined.

14.6.16.1 The CONTRACTOR shall submit void Encounters for Claims that are recouped in full.

14.6.16.2 The CONTRACTOR shall submit void Encounters and replacement Encounters where information has been reprocessed or corrected. The replacement claim control number (CCN) must not be the same as the original CCN.

14.6.17 Accepts the Department's use of the Encounter record for the following reasons:

14.6.17.1 To evaluate access to health care, availability of services, Quality of care, and cost effectiveness of services,

14.6.17.2 To evaluate contractual performance,

14.6.17.3 To validate required reporting of utilization of services,

14.6.17.4 To develop and evaluate proposed or existing Capitation Payments.

14.6.17.5 To meet CMS Medicaid reporting requirements, including Transformed Medicaid Statistical Information System (TMSIS),

and

14.6.17.6 For any purpose the Department deems necessary.

14.6.18 Encounter Data Requirements for Certain Drugs

The Contractor shall maintain adequate systems, policies, and procedures to ensure that Encounter submissions are complete and accurate. At a minimum, for physician administered drug claims to be considered complete and accurate Encounter submissions, they must contain a valid HCPCS code and NDC code combination in order for the Department to obtain all appropriate rebates and ensure full compliance with the requirements within 42 CFR § 447.520.

14.6.18.1 Should an inaccurate Encounter be accepted due to incorrect data elements, the Department shall work with the CONTRACTOR and the CONTRACTOR must cooperate with any efforts to correct such encounters so that appropriate rebateable drugs may be submitted for rebates.

14.6.18.2 In the instance that an inaccurate encounter submission results in the inability of the Department to submit a valid drug for rebate, the Department shall hold the CONTRACTOR responsible for the total value of the lost rebate, which may be recouped on future Capitation Payments.

14.6.18.3 Drug utilization information that includes, at a minimum, information on the total number of units of each dosage form, strength, and package size by National Drug Code (NDC) of each covered outpatient drug dispensed or covered by the Contractor.

14.7 Eligibility and Enrollment Exchange Requirements

The CONTRACTOR shall:

14.7.1 Systematically update its eligibility/Enrollment databases within twenty-four (24) hours of receipt of said files.

14.7.1.1 Any outbound 834 transactions that fail to update/load systematically must be manually updated within twenty-four (24) hours of receipt.

14.7.2 Report to the Department, in a form and format to be provided by the Department, 834 transactions that are not processed within these time frames and include information regarding when the transactions were completed.

14.7.3 Initiate a Corrective Action Plan (CAP) for resolution of the issues preventing compliance resulting from any transactions that are not updated/loaded within twenty-four (24) hours of receipt from the Department and/or persistent issues with high volumes of transitions that require manual upload.

14.7.3.1 If the CONTRACTOR has reason to believe they may not meet this requirement based on unusual circumstances, the CONTRACTOR must notify the Department and the Department may make an exception without requiring a CAP.

14.7.4 Transmit to the Department, in the formats and methods specified in the HIPAA implementation and the Department's companion guides or as otherwise specified by the Department: member address changes, telephone number changes, and PCP.

14.7.5 Be capable of uniquely identifying a distinct Member across multiple populations and systems within its span of control.

14.7.6 Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by the Department, resolve the duplication such that the Enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

14.8 FQHC/ RHC Encounter Reporting

To ensure appropriate payment levels and comply with 1903(m)(A)(ix), the CONTRACTOR shall:

14.8.1 Submit a quarterly report of Encounter/Claims data, organized by date of service, for all contracting FQHCs and RHCs for State Plan required reconciliation purposes.

14.8.2 Refer to the Managed Care Report Companion Guide for FQHC/RHC report specifications.

14.9 Errors and Encounter Validation

14.9.1 The CONTRACTOR agrees to submit complete and accurate Encounter files, containing all paid Claims to the Department. This requirement involves the following standards and responsibilities:

14.9.1.1 Daily File Submissions

14.9.1.1.1 The CONTRACTOR should submit Encounter files daily.

14.9.1.1.2 The Department shall aggregate submitted Encounters on a monthly basis.

14.9.1.1.3 Departmental Validation shall occur daily, monthly, and quarterly on the aggregated Encounter records.

14.9.1.2 Corrected Encounter Resubmissions

The Department shall generate a 277CA response file for all submitted Encounter records on a timely basis, to allow the CONTRACTOR sufficient time to resubmit and correct any erred Encounters.

14.9.1.3 Corrected Encounter Resubmissions Deadlines

The CONTRACTOR shall correct and resubmit previously denied Encounter records within ninety (90) Calendar Days after the initial Encounter reporting

due date. An Encounter record that is accepted by the Department shall be considered in the completion percentage.

14.9.1.4 Encounter Submission Accuracy Requirements

The CONTRACTOR shall conduct Validation studies of Encounter data, testing for timeliness, accuracy, and completeness.

14.9.2 If the Department, or the CONTRACTOR, determines at any time that the CONTRACTOR's Encounter data is not complete and accurate, the CONTRACTOR shall be responsible for the following requirements:

14.9.2.1 Document and Quantify Rejected Encounters

The CONTRACTOR shall document and quantify rejected Encounters as a percentage of the CONTRACTOR paid Claims amount for the monthly reporting period. This is required whenever the submitted Encounter data is not at least ninety-seven percent (97%) complete either in total or for any individual Encounter type NCPDP, institutional (837I), and professional 837(P).

14.9.2.2 Action Plan

The Contractor shall submit for Department approval an action plan and timeline for resolution of rejected Encounters with the proposed resolution accomplished within sixty (60) Days. Such documentation and any associated action plan are to be submitted along with the monthly report, under separate cover. Such action plan is required when the accepted Encounter percentage falls below ninety-seven percent (97%) for any reporting month in total or for any individual Encounter type NCPDP, institutional (837I), and professional 837(P).

14.9.2.2.1 Failure of the CONTRACTOR to adhere to the action plan will result in liquated damages outlined in *Section 18* of the contract.

14.9.3 Encounter data received from the CONTRACTOR shall be edited by standards established by the Department.

14.9.4 The Department shall reject individual Encounters failing critical edits, as deemed appropriate and necessary by the Department to ensure accurate processing or Encounter data quality and will return these transactions to the CONTRACTOR for research and resolution.

14.9.4.1 An Erred Encounter Record File shall be transmitted to the CONTRACTOR electronically and responded back within two (2) Business Days by the CONTRACTOR for correction of the interchange acknowledgement TA1.

14.9.5 The Department shall require expeditious action on the part of the CONTRACTOR to resolve errors or problems associated with said Claims or the adjudication thereof, including any necessary changes or corrections to any systems, processes or data transmission formats, in accordance with the Procedures specified in Department's companion guides.

14.9.5.1 Generally, the CONTRACTOR shall, unless otherwise directed by the Department, address one hundred percent (100%) of reported errors within ninety (90) Calendar Days.

14.9.5.2 Such errors will be considered acceptably addressed when the CONTRACTOR has either confirmed and corrected the reported issue or disputed the reported issue with supporting information or documentation that substantiates the dispute.

14.9.5.2.1 The Department may require resubmission of the transaction with reference to the original to document resolution.

14.10 Data Validation

14.10.1 Encounter Validation Studies

14.10.1.1 Per CMS requirements, the Department or its agents will conduct Encounter Validation studies of the CONTRACTOR's Encounter submissions including data from network Providers the CONTRACTOR is compensating on the basis of Capitation Payments. These studies may result in sanctions of the CONTRACTOR and/or require a CAP for noncompliance with related Encounter submission requirements.

14.10.1.2 The purpose of Encounter Validation studies is to compare recorded utilization information from a Health Record or other source with the CONTRACTOR's submitted Encounter data. Any and all Covered Services may be validated as part of these studies.

14.10.1.3 The criteria used in Encounter Validation studies may include timeliness, correctness, and omission of Encounters.

14.10.2 Data Quality Efforts

Data quality efforts of the Department shall incorporate the following standards for monitoring and Validation:

14.10.2.1 Edit each data element on the Encounter records for required presence, format, consistency, reasonableness and/or allowable values,

14.10.2.2 Edit for Member eligibility,

14.10.2.3 Perform automated audit processing (e.g. duplicate, conflict, etc.) using history Encounter record and same-cycle Encounter record,

14.10.2.4 Identify exact duplicate Encounter records,

14.10.2.5 Maintain an audit trail of all error code occurrences linked to a specific Encounters, and

14.10.2.6 Update Encounter history files with both processed and incomplete Encounter records.

The CONTRACTOR shall:

14.10.3 Participate in site visits and other reviews and assessments by CMS and the Department, or its designee, for the purpose of evaluating the CONTRACTOR's collection and maintenance of Encounter data.

14.10.4 Upon request by the Department, or their designee, provide Health Records of Members and a report from administrative databases of the Encounters of such Members to conduct Validation assessments.

14.10.5 Be aware that such Validation assessments may be conducted annually.

14.10.6 Be notified in writing of any significant change in study methodology. The Department may revise study methodology, timelines and sanction amounts based on agency review or as a result of consultations with CMS.

14.10.7 Upon request, reconcile all Encounter data submitted to the State to control totals and to the CONTRACTOR's Medical Loss Ratio (MLR) reports and supply the reconciliation to the Department with each of the MLR report submissions as specified in the Managed Care Report Companion Guide.

14.10.8 Submit quarterly Encounter Quality Initiative (EQI) reports to the Department for complete and accurate reporting and reconciliation of Encounter submissions with CONTRACTOR experience and for rate setting and base data verification purposes.

14.10.8.1 This is to be done in a timely, complete, and accurate manner.

14.10.8.2 The data elements, and other Department requirements, can be found in the Managed Care Report Companion Guide.

14.10.8.3 EQI reports are due within one hundred and twenty-one (121) Days of the end of each calendar quarter.

14.10.8.4 The Department reserves the right to change the method of data completion verification upon reasonable advance notice to the Contractor.

14.11 System and Information Security and Access Management Requirements

The CONTRACTOR shall:

14.11.1 Ensure its systems employ an access management function that restricts access to varying hierarchical levels of system functionality and information based on the following standards:

14.11.1.1 Restrict access to information on a "least privilege" basis, e.g., users permitted inquiry privileges only will not be permitted to modify information;

14.11.1.2 Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by the Department and the CONTRACTOR.

14.11.1.3 Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

14.11.2 Make System information available to duly authorized representatives of the Department and other state and federal agencies to evaluate, through inspections or other means, the Quality, appropriateness, and timeliness of services performed.

14.11.3 Ensure its Systems shall develop and maintain a security and privacy program with effective security and privacy controls compliant with the most current version of the CMS Minimum Acceptable Risk Standards for Exchanges (MARS-E), Catalog of Minimum Acceptable Risk Security and Privacy Controls for Exchanges, or the most current release of CMS' security and privacy control catalog and/or framework. Security and privacy controls shall be well documented, management-enforced and comply with all applicable security and privacy laws, regulations, and policies, including the Health Insurance Portability and Accountability Act (HIPAA), Medicaid Safeguarding, and related breach notification laws and directives.

14.11.3.1 These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits.

14.11.4 Incorporate an audit trail into all systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

14.11.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

14.11.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;

14.11.4.3 Have the ability to trace data from the final place of recording back to its source data file and/or document;

14.11.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs;

14.11.4.5 Facilitate auditing of individual records as well as batch audits;

14.11.4.6 Be maintained online for no less than two (2) years; additional history shall be retained for no less than ten (10) years and shall be retrievable within forty-eight (48) hours.

14.11.5 Have inherent functionality within its systems that prevents the alteration of finalized records.

14.11.6 Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein.

14.11.6.1 The CONTRACTOR shall provide the Department with access to data facilities upon request. The physical security provisions shall be in effect for the life of this agreement.

14.11.7 Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

14.11.8 Include physical security features designed to safeguard processor site(s) through required provision of fire-retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

14.11.9 Install Procedures, measures, and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CONTRACTOR's span of control.

14.11.9.1 This includes but is not limited to, Provider and Member service applications shall be HIPAA protected to ensure appropriate access.

14.11.10 Ensure that remote access users of its systems can only access said systems through two-factor user authentication and via methods such as virtual private network (VPN).

14.11.11 Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing.

14.11.11.1 At a minimum, the CONTRACTOR shall conduct a security risk assessment and communicate the results in an information security plan provided prior to the start date of operations.

14.11.11.2 The risk assessment shall also be made available to appropriate federal agencies.

14.12 Subcontractor(s) and Encounter Data Reporting

14.12.1 Interfaces

14.12.1.1 All Encounter data shall be submitted to the Department directly by the CONTRACTOR.

14.12.1.2 The Department shall not accept any Encounter data submissions or correspondence directly from any Subcontractors, and the Department shall not forward any electronic media, reports, or correspondence directly to a Subcontractor.

14.12.1.3 The CONTRACTOR shall be required to receive all electronic files and hardcopy material from the Department, or its appointed fiscal agent, and distribute said files and materials within its organization or to its Subcontractors as needed.

14.12.2 Communication

14.12.2.1 The CONTRACTOR and its Subcontractors shall be represented at all Department meetings scheduled to discuss any issue related to the Encounter data requirements.

14.12.2.2 All Subcontracts with Providers or other vendors of service including data from network Providers the CONTRACTOR is compensating on the basis of Capitation Payments must have provisions requiring that Encounter records be reported/submitted in an accurate and timely fashion. (42 CFR § 438.242(b)(3)(i))

14.13 Future Encounter Data Reporting Requirements

The CONTRACTOR shall be responsible for completing and paying for any modifications required to submit Encounter data electronically, according to the same specifications and timeframes outlined by CMS for the Department's MMIS and/or Encounter Processing System (EPS).

Section 15. QUALITY MANAGEMENT AND PERFORMANCE

15.1 General Requirements

Section 1932(c)(1) of the Social Security Act (SSA) sets forth specifications for Quality Assessment and Performance Improvement strategies that states must implement to ensure the delivery of Quality health care by all Managed Care Entities (MCEs). Pursuant to 42 CFR §§, 438.330 and 438.340, the Department must ensure all Managed Care CONTRACTORs comply with Quality Assessment and Performance Improvement (QAPI) standards established by the State.

The CONTRACTOR shall:

15.1.1 Ensure all CONTRACTOR Quality management and performance activities are compliant with federal and state rules and regulations.

15.1.2 Have an ongoing Quality Assessment and Performance Improvement (QAPI) Program aimed at improving the Quality of the services furnished to its Members (42 CFR § 438.330(e)(2) and 42 CFR § 438.310(c)(2)).

15.1.3 Have mechanisms to detect both underutilization and overutilization (42 CFR § 438.330(b)(3)).

15.1.4 Have mechanisms to assess the Quality and appropriateness of care furnished to Members with special health care needs, as defined by the State in the quality strategy under § 438.340 (42 CFR § 438.330(b)(4)).

15.1.5 Measure and report to the Department its performance, using standard measures required by the Department, including those that incorporate the requirements of 42 CFR §§ 438.330.

15.1.6 Submit data and reports specified by the Department that enables the Department to measure the CONTRACTOR's performance.

15.1.7 Ensure its Quality and performance programs are consistent with National Committee for Quality Assurance (NCQA) Health Plan accreditation requirements.

15.1.7.1 The Department shall review submitted materials to gain further insight into the quantitative and qualitative performance of the Contractor during the accreditation process.

15.1.7.2 The Department shall review the provided NCQA Health Insurance Plan rating to ensure the Contractor's score is a value of three and one-half (3.5) or greater.

And,

15.1.8 Adopt reimbursement models that incentivize the delivery of high-quality care.

15.2 Performance Improvement Projects (PIPs)

The CONTRACTOR shall:

15.2.1 Conduct Performance Improvement Projects (PIPs) that are designed to achieve, through ongoing measurements and intervention, significant improvement in both clinical and

nonclinical areas that are expected to have a favorable effect on health outcomes and/or Member satisfaction (42 CFR § 438.330).

15.2.2 Include the following in the development and performance of PIPs:

15.2.2.1 Measurement of performance using objective Quality measures and indicators.

15.2.2.2 Implementation of system interventions to achieve improvement in the access to and quality of care.

15.2.2.3 Evaluation of the effectiveness of the intervention(s).

15.2.2.4 Planning and initiation of activities for increasing or sustaining improvements realized through the PIP.

15.2.3 Report the status and results of each project to the Department quarterly and as requested.

15.2.4 Complete each PIP in a reasonable time period so as to generally allow information on the success of Performance Improvement Projects in the aggregate to produce new information on quality of care every year.

15.2.5 Be aware the Department may specify the topic of the CONTRACTOR's PIP activities.

15.3 Quality Assurance (QA) Committee

The CONTRACTOR shall:

15.3.1 Ensure its QAPI activities are directed by a QA Committee which has the substantial involvement of the CONTRACTOR's medical and quality directors and includes membership from:

15.3.1.1 A variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.).

15.3.1.2 Participating network Providers from a variety of medical disciplines with emphasis on primary care—including obstetric and pediatric representation.

15.3.1.3 Representation from the CONTRACTOR's management or Board of Directors.

15.3.2 Be required to locate the QA Committee within the CONTRACTOR such that it can be responsible for all aspects of the QAPI program.

15.3.3 Require the QA Committee meet at least quarterly.

15.3.4 Require the QA Committee to produce dated and signed written documentation of all meetings and committee activities and make these documents available to the Department upon request.

15.3.5 Integrate the QAPI activities of CONTRACTOR's Subcontractors into the overall CONTRACTOR QAPI program.

15.3.5.1 The CONTRACTOR's QAPI program shall provide feedback to the Providers and Subcontractors regarding the integration of, operation of, and corrective actions necessary in Provider/Subcontractor QAPI efforts.

15.3.6 Have written Procedures that address the CONTRACTOR's approach to measurement, analysis, and interventions for QAPI activity findings.

15.3.7 Document, in writing, the measurement, analysis and interventions, submit these data to the CONTRACTOR's Board of Directors and make them available to the Department upon request.

15.4 Member Satisfaction Survey

The CONTRACTOR shall:

15.4.1 Use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program, a program of the US Agency for Healthcare Research and Quality (AHRQ)'s, CAHPS Health Plan Survey, as required by NCQA for accreditation of a Medicaid Health Plan, as its primary instrument for the measurement of Member satisfaction.

15.4.1.1 CAHPS related activities must be performed by an NCQA-certified CAHPS survey vendor.

15.4.1.2 The CONTRACTOR may elect to employ additional tools to supplement the CAHPS survey. These tools may include the use of additional Member surveys, anecdotal information gathered from Member or Provider interactions, Grievance and Appeals data, and Enrollment and Disenrollment information.

15.4.2 Submit its CAHPS results to the Department by July 31st of each year.

15.4.2.1 To facilitate the submissions of the Quality measures by the Department to CMS, the Contractor shall implement and submit to the Department results from all three of the following separately administered CAHPS surveys:

15.4.2.1.1 CAHPS Health Plan Survey, Adult Version

15.4.2.1.2 CAHPS Health Plan Survey, Child Version (not including Children with Chronic Conditions questions)

15.4.2.1.3 CAHPS Health Plan Survey, Child Version (including Children with Chronic Conditions questions)

15.4.2.1.4 The required data submissions for the above-mentioned surveys shall include, at a minimum:

15.4.2.1.4.1 Final CAHPS data submission to NCQA (IDSS)

15.4.2.1.4.2 CAHPS Survey Data Files

15.4.2.1.4.3 NCQA Member-Level Data Files

15.4.2.1.4.4 South Carolina-specific Member-Level Data Files, if applicable

15.4.2.1.4.5 CAHPS Survey instrument used

15.4.2.1.4.6 South Carolina- specific CAHPS Final Report

15.4.2.2 The CONTRACTOR shall provide CAHPS data in an editable format that allows for aggregation and analysis of the raw data.

15.4.2.3 The CONTRACTOR shall report the results of any additional Member satisfaction measurement or improvement efforts to the Department annually, along with the CAHPS data submission.

15.4.3 Develop a Corrective Action Plan when Members report significant levels of dissatisfaction, when a pattern of complaint is detected, or when a serious complaint is reported.

15.5 Quality Performance Measures

The CONTRACTOR shall:

15.5.1 Measure and report to the Department its performance, using standard measures required by the Department, including those measures that may be required by the Centers for Medicare and Medicaid Services.

15.5.1.1 The Contractor shall notify the Department at any point if the Contractor determines that it is unable to report an individual HEDIS measure or set of HEDIS measures.

15.5.2 Report to the Department all NCQA Medicaid Health Plan measures, in addition to any other measures specified in the Managed Care Report Companion Guide.

The CONTRACTOR shall:

15.5.2.1 Contract with an NCQA-licensed audit organization (LO) to undergo an NCQA HEDIS Compliance Audit conducted by an NCQA- Certified HEDIS Compliance Auditor (CHCA). The CONTRACTOR shall fully comply with such guidance as is necessary for NCQA to accept the CONTRACTOR's annual HEDIS submission for the CONTRACTOR's Medicaid membership, whenever HEDIS submission is required as part of the CONTRACTOR's accreditation with NCQA.

15.5.2.2 Submit to the Department the Final Auditor's Report (FAR), the final, auditor-locked version of the Interactive Data Submission System (IDSS), and any other files or documents required by the Department in the stipulated format by no later than July 31st – after completion of the CONTRACTOR's annual HEDIS data collection, reporting and performance measure audit.

15.5.3 Provide to the Department the data necessary to measure and analyze performance for Quality metrics, which may include data from previous years, in the format to be detailed by the Managed Care Report Companion Guide, or as otherwise requested by the Department. Such data may include measures that are not part of HEDIS, for example, the CMS Adult and Child Core Quality Measures.

15.5.3.1 The CONTRACTOR shall ensure executive, technical, and subject matter support for such quality program measurements and requirements as may be required or encouraged for CMS for states to implement.15.5.3.2 The

Contractor shall ensure that its Medicaid Providers make records accessible and available for review during a Provider's normal business hours or as otherwise directed, with or without advance notice by authorized entities and staff as described in this section. An authorized entity may either copy, accept a copy, or may request original records. Any requested record(s) is deemed inaccessible if not available within two (2) hours of the request when requested by an authorized entity.

15.6 Quality Withhold and Bonus Program

The CONTRACTOR shall participate in a Quality Withhold and Bonus Program, in which the CONTRACTOR is at-Risk for performance incentives based on Quality objectives for a calendar year and is eligible to receive additional funds for meeting targets specified in this contract. (42 CFR § 438.6(b)(3)(i) - (v); 42 CFR § 438.340)

Incentive Payments that are paid to CONTRACTOR under this program shall be below 105% of the certified Capitation Payments paid to the Contractor under this contract. Incentive Arrangements and Quality Withholds outlined in this Contract shall be in accordance with 42 CFR § 438.6(b).

The Department reserves the right not to make Incentive Payments to the Contractor should the Contractor fail to submit timely and accurate reports in the format outlined in this Contract and the Managed Care Report Companion Guide. The Department, in its sole its discretion, may recoup Incentive Payments should the Department discover the Contractor has submitted erroneous information related to Incentive Payments. The Department's recoupment of Incentive Payments may include both the Contractor's and Provider's portion of the Incentive Payment and may result in the assessment of liquidated damages as outlined in *Section 18* of this contract.

15.6.1 Quality Withhold Program

The Department shall withhold a specific percentage of the CONTRACTOR's total Capitation Payment, as specified within the annual rate certification and the Managed Care Report Companion Guide. The Department shall execute a Withhold of capitation rates equal to one and a half percent (1.5%) of the overall sum of rates for the calendar year, not to include teaching supplements, quality incentive payments, and gross level adjustments for the next Reporting Year (RY). The withhold shall be applied retrospectively to the capitation rate payment and shall be executed via gross level adjustment. If the Contractor has a MMP, the Department shall use the Medicare-Medicaid combined report for HEDIS data submission for the purpose of evaluating performance related to the Quality Withhold Program.

The Department shall continue to operate the withhold and Bonus Program outlined in this section of the contract and the Managed Care Report Companion Guide. The following provisions shall apply to the withhold Program:

The CONTRACTOR shall:

15.6.1.1 Meet the Alternative Payment Model (APM) target, as described in *Section 15* of this contract. Failure to meet the APM target shall result forfeiture of twenty-five (25) percent of the withhold dollars.

15.6.1.2 Earn back withhold funds by meeting performance and improvement standards on Quality Indices of HEDIS metrics, as defined in the table below (Exhibit 4).

15.6.1.3 Demonstrate a minimum level of Quality performance, as defined in the Managed Care Report Companion Guide. Failure to meet the minimum level of Quality performance may result in liquidated damages as reflected in *Section 18*.

Exhibit 4- SCDHHS Medicaid Managed Care Quality Index Scores and Withhold Actions

INDEX Score	**Withhold Action**
<1.5	Full index withhold amount forfeited
1.5	75% of index withhold amount forfeited.
2.0 to 2.5	50% of index withhold amount forfeited.
3.0 to 4.0	Full index withhold amount returned to Plan.
4.5 to 5.0	Full withhold amount returned and eligible for bonus.

15.6.2 Bonus Pool

Funds not earned back through the withhold program shall create a Bonus pool. Bonuses will be paid to CONTRACTORs based on criteria detailed in this section of the Contract. Bonuses will be paid based on performance during the fixed time period of the previous calendar year. (42 CFR § 438.6(b)(2)(i))

In the event the contract is terminated with the CONTRACTOR, the CONTRACTOR shall:

15.6.2.1 Forfeit any and all withhold funds for the calendar year in which the termination occurs.

15.6.2.2 Refund to the Department any and all incentive monies paid to the CONTRACTOR, excluding any Provider-Designated Incentives, for the calendar year of the termination. The refund may exclude Provider-designated incentive paid and distributed upon authorization by the Department.

15.6.2.3 Be solely responsible for the refund and shall not seek or attempt to collect any part of the incentive from any Provider to whom the CONTRACTOR had previously paid a portion of the incentive.

15.6.3 Quality Withhold and Bonus Program Requirements for New Contractors

During the first two (2) years of operation in the South Carolina Medicaid market, a modified Bonus and withhold Program shall govern a new CONTRACTOR.

15.6.3.1 Benchmark Year: The Benchmark Year is the first full calendar year for which the Contractor is active in the SC Medicaid Market.

15.6.3.1.1 The Quality Withhold and Bonus Program, including liquidated damages for failure to meet the Minimum Performance Standard (MPS), shall not apply during the Benchmark Year.

15.6.3.2 Transition Year: The Transitional Year is the second full calendar year for which the Contractor is active in the SC Medicaid Market.

15.6.3.2.1 During the Transition Year, the Contractor is required to achieve the APM requirements outlined in the contract.

15.6.3.3 For each Withhold Index where the Contractor fails to achieve a composite score of four (4) or better, the Contractor is responsible for achieving improvement to avoid withhold forfeiture. Improvement is defined as increasing the total withhold index score, as reported by NCQA, from the Benchmark year. Withhold forfeiture will be equal to the amount reflected in the table (Exhibit 5 below.

15.6.3.4 The standard Withhold and Bonus Program policy shall apply to the Contractor beginning with its 3rd full year of operation.

Exhibit 5- Withhold Actions Based on Index Scores

INDEX SCORE CHANGE FROM BENCHMARK YEAR	**WITHHOLD ACTION**
Decrease	Full withhold forfeited
Remains the same	50% of Index withhold forfeited
Improves by .5 or higher	Full Index withhold returned
4.0-5.00	Full Index withhold returned and eligible for bonus

15.6.4 Calculating the Withhold Actions and Bonuses

In order to calculate the Contractor's Withhold Actions and Bonuses, the Department shall first determine the first pass index scores and withhold actions. The Department will note which of the SC Medicaid Managed Care Organizations scored in a range of 4.5 to 5.0 for each composite.

All forfeited funds not distributed within the First Pass Quality Withhold Indices, including any forfeited dollars not meeting Alternate Payment Methodology requirements, shall be transferred to the Bonus Pool and distributed to each index on an equally weighted basis and subdivided equally to each of the State's Managed Care Organizations that achieved in the range of 4.5 to 5.0 points on the index.

15.7 Incentive Payments

In addition to the Bonus Pool as described in this section, incentive arrangements may be issued for the specified activities, targets, performance measures, and quality-based outcomes that support program initiatives as specified in the Department's quality strategy and are in accordance with 42 CFR § 438.6(b)(2).

15.7.1 Provider Incentives

15.7.1.1 Quality Achievement Program

The Department may offer the CONTRACTOR an option to participate in a Department approved Quality Achievement project as necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives as specified in the Department's quality strategy pursuant to the authority and limitations reflected in 42 CFR 438 6(b)(2).

15.7.1.1.1 The Department will specify, for each project, the quality strategy objectives and the activities, targets, performance measures, or quality outcomes to be achieved and how each will be evaluated. The Department's determination of CONTRACTOR's achievement will be based on documentation submitted by CONTRACTOR reflecting performance, or by the CONTRACTOR's representative if CONTRACTOR contracts with a third party to assist in CONTRACTOR's satisfaction of the projects. The Department shall timely notify CONTRACTOR regarding satisfaction of each project for the applicable measurement period and the amount of any attributable quality payment for which the CONTRACTOR is eligible.

15.7.1.1.2 The Department agrees that neither CONTRACTOR's decision whether to participate in a project or failure to succeed under an Achievement Project, shall have any impact on CONTRCTOR's rights or obligations under this contract, except as it relates specifically to the program and payments set forth in this section of the contract.

15.7.1.2 Patient Centered Medical Home (PCMH)

PCMH is a comprehensive care delivery model designed to improve the quality of primary care services for Members, the capabilities of and practice standards of Primary Care Providers, and the overall value of health care delivered to the Members.

The goal is to encourage the development of PCMH as defined through the certification process through the National Committee for Quality Assurance (NCQA), as well as other recognized PCMH recognition bodies that SCDHHS may deem credible.

PCMH incentive payments apply to all in-State Medicaid enrolled Providers who achieve PCMH recognition. In-State Medicaid enrolled Providers are defined as anyone residing within the State or within 25 miles of the South Carolina State border. If a Provider achieves PCMH recognition, both the Provider and the Contractor shall receive an increased incentive beginning the month in which PCMH recognition was achieved. Contractor incentive payments for PCMH Provider payments shall be paid through gross level adjustment after a quarter's end.

The Contractor Shall:

15.7.1.2.1 Submit to the Department, a monthly report by the fifteenth (15th) day of the following month, the total number of Members assigned to each qualifying Provider. Refer to the Managed Care Report Companion Guide for detailed reporting requirements.

15.7.1.2.1.1 Once the Department has made its quarterly payments to the Contractor, the Contractor shall make payment to the qualifying practices within thirty (30) Days of the Department's payment.

15.7.1.2.1.2 Retroactive requests and corrected files may only be backdated one quarter. The Department will not pay the Contractor for retroactive PCMH data outside of the prior quarter.

15.7.2 Member Incentives

The CONTRACTOR may offer Incentives to encourage Members to change or modify behaviors or meet certain goals. Members must complete a Qualifying Healthy Behavior to receive an incentive. Qualifying Healthy Behaviors include, but are not limited to, doctor visits, health Screenings, immunizations, etc. The Department shall not provide any additional payment or reimbursement for Member Incentives.

The CONTRACTOR shall:

15.7.2.1 Only offer Member Incentives to those Members who are enrolled with the Contractor.

15.7.2.2 Prepare a description of the Member Incentive(s) which possess a value of more than $25 that the Contractor seeks to offer to Members and submit it to the Department for approval. Incentives may not include cash, alcohol, tobacco, ammunition, weapons, or gift cards that may be used to purchase the aforementioned items.

15.7.2.2.1 The description and request for approval shall include the reporting to be provided to the Department to assess the impact of the incentive, a list of Qualifying Healthy Behavior(s) and the resulting incentive, and a description of how the Contractor will verify that a Qualifying Healthy Behavior has been completed.

15.7.2.2.2 The Contractor shall not be required to submit Member Incentive requests to the Department for incentive items where the amount is $25 or less per Qualifying Healthy Behavior.

15.7.2.2.3 All submissions for Member Incentives more than $25 shall be submitted in the form and manner as described by the Department and as detailed in the Managed Care Report Companion Guide.

15.7.2.3 No offers of material or financial gain shall be made to any Member as incentive to enroll or remain enrolled with the Contractor; this includes, but is not limited to, cash, vouchers, gift certificates, insurance Policies, or other incentives.

15.7.2.4 Upon approval by the Department, include and incorporate the Member Incentive as part of the CONTRACTOR's benefit and Member materials. The Contractor shall follow appropriate Material Review processes prior to use, in accordance with *Section 12* of this contract.

15.7.2.5 Be responsible for transportation services if transportation is part of these Member Incentives.

15.7.2.6 Receive Department approval prior to implementing any modifications to Member Incentives greater than $25.

15.7.2.7 Continue to offer the Member Incentive until the Department has approved the request to modify or discontinue the Member Incentive.

15.7.2.8 Reimburse the Department for any cost, charges or expenses incurred by the Department or its designee for changes to the

website grids, member and Provider notifications or any other related requirements not listed here.

15.8 Alternative Payment Models (APM)

The purpose of APMs is to improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes.

The CONTRACTOR shall:

15.8.1 Adopt reimbursement models that shift away from standard FFS reimbursement towards Alternative Payment Models (APM).

15.8.2 Design and implement payment methodologies with its network Providers that adopt the following parameters, as defined by the Department and detailed in the Managed Care Report Companion Guide in accordance with 42 CFR § 438.6(b)(1):

15.8.2.1 Payment for Performance.

15.8.2.2 Episodes of Care.

15.8.2.3 Shared Savings Arrangements

15.8.2.4 Shared Risk Arrangements.

15.8.2.5 Capitation Payments with Performance and Quality Requirements.

15.8.3 Agree that Prior Authorization and utilization management activities do not satisfy the definition of APM.

15.8.4 Implement APMs and reach the following targets for each measurement year as outlined in *Exhibit 6*.

Exhibit 6. CONTRACTOR Targets for APMs by Calendar Year

Year	**Target**
January 1, 2021 – December 31, 2021	30% of total payments
January 1, 2022 – December 31, 2022	30% of total payments
January 1, 2023 – December 31, 2023	30% of total payments
January 1, 2024 – December 31, 2024	30% of total payments
January 1, 2025 – December 31, 2025	30% of total payments

15.8.5 Report Alternative Payment Models (APM)

15.8.5.1 The methodology for evaluating the APM percentage and the reporting requirements related to the APM requirement shall be detailed in the Managed Care Report Companion Guide.

15.8.5.1.1 At the end of the APM reporting period described above, if requested by the Department, the Contractor should be prepared to present to the Department, in person, a presentation of past activities and outcomes.

15.8.5.2 Failure to meet the minimum target for each measurement year will result in the CONTRACTOR forfeiting twenty-five (25%) percent of withhold dollars as described in *Section 15*.

15.8.5.3 The Department reserves the right to audit any contract claimed to qualify as APM as well as any payments claimed to have been made pursuant to a APM contract.

15.8.5.4 The determination for whether a Provider contract qualifies as a APM shall rest solely with the Department.

15.8.5.4.1 The Department may request additional information about value-based contracting which may include, but is not limited to, an annual summary report of value based contracting activities and the effectiveness and outcomes based on the structure of the agreements.

15.8.6 Physician Incentive Plan

The Contractor Shall:

15.8.6.1 Apply all rules as it pertains to Physician Incentive Plans in accordance with Section 1903(m)(2)(A)(x) of the Social Security Act, 42 CFR 422.208(c), and 42 CFR 438.3(i).

15.8.6.2 Only operate a Physician Incentive Plan under the following conditions:

15.8.6.2.1 No specific payment can be made directly or indirectly under a Physician Incentive Plan to a Physician or Physician group as an inducement to reduce or limit Medically Necessary Services furnished to an individual Member.

15.8.6.2.2 If the Contractor puts a Physician/Physician group at substantial financial risk for services not provided by the Physician/Physician group, the Contractor must ensure that the Physician/Physician group has adequate stop-loss protection.

And

15.8.6.2.3 Member survey and disclosure requirements are met.

15.9 NCQA Accreditation Standards and Requirements

The CONTRACTOR shall:

15.9.1 Secure, at a minimum, Interim Health Plan Accreditation status from NCQA prior to contracting with the Department. In addition to the Interim Health Plan Status Accreditation status provision, the CONTRACTOR must continue its pursuit to achieve "Accredited" status and NCQA Health Equity Accreditation within the timeframe(s) detailed in this Section of the contract.

15.9.2 Achieve at a minimum "Accredited" status from NCQA within two (2) years of entering the South Carolina Medicaid market.

15.9.3 The CONTRACTOR must earn NCQA's Health Equity Accreditation in calendar year 2023.

15.9.4 Once achieved maintain the "Accredited" status and NCQA Health Equity Accreditation through the term of the contract.

15.9.5 If one of the anniversary requirement dates described in this Section of the Contract occurs during a HEDIS evaluation period, the results at the conclusion of the evaluation shall be used in assessing the CONTRACTOR's status.

15.9.6 The Department has discretion to impose liquidated damages, cease the Enrollment of additional Members to the CONTRACTOR's Health Plan, and reassign Members who are currently enrolled in the CONTRACTOR's Health Plan during the period between the CONTRACTOR's failure to achieve accreditation and/or Health Equity Accreditation and the subsequent review.

15.9.7 Inform the Department of its status with NCQA and any changes to that status throughout the term of this contract. The CONTRACTOR shall communicate the results of any accreditation review to the Department within five (5) Calendar Days of receipt of the results.

15.9.8 The CONTRACTOR shall authorize NCQA and any other accrediting entity to provide the Department with a copy of its most recent review(s) as required by 42 CFR § 438.332(a) and 42 CFR § 438.332(b)(1) – (3), including:

15.9.8.1 Accreditation status, type, and level

15.9.8.2 Recommendations for improvement, Corrective Action Plans, and summaries of findings

15.9.8.3 Expiration date of accreditation

15.9.8.4 Health Equity Accreditation survey results

15.9.8.5 Expiration date of Health Equity Accreditation recognition

15.10 External Quality Review (EQR)

The CONTRACTOR shall:

15.10.1 Participate and cooperate in an annual External Quality Review in accordance with 42 CFR § 438.350. The review shall include, but shall not be limited to, review of Quality outcomes, timeliness of, and access to, the services covered under the contract.

15.10.2 Provide all information and documentation required to complete the review as requested by the Department or its designee. The External Quality Review Organization (EQRO) will coordinate with the Contractor to schedule the review and to communicate the EQRO's expectations.

15.10.2.1 Such audits shall allow the Department or its Representative to identify and collect management data.

15.10.2.2 The standards by which the CONTRACTOR will be surveyed and evaluated will be at the Department's sole discretion.

15.10.2.3 If deficiencies are identified, the CONTRACTOR must submit a Corrective Action Plan (CAP) for approval addressing how the CONTRACTOR will remediate any deficiencies and the timeframe in which such deficiencies will be corrected. The Department has the discretion to impose Liquidated Damages for repeat findings identified during an annual External Quality Review.

15.10.2.4 The CONTRACTOR must receive prior approval from the Department for the CAP.

15.10.3 The CONTRACTOR shall submit periodic updates to the Department, at a frequency determined by the Department, regarding its progress in correcting the deficiencies.

15.10.3.1 All Corrective Action Plans and their updates must include an attestation to completeness and accuracy and be signed by the Contractor's CEO.

15.11 Provider Preventable Conditions (PPC)

The CONTRACTOR shall:

15.11.1 Implement and maintain a no payment policy and a quality monitoring Program consistent with the Centers for Medicare and Medicaid Services (CMS) requirement that addresses Hospital Acquired Conditions (HACs) and Provider- Preventable Conditions (PPCs) and according to federal regulations at 42 CFR § 438.3(g), 42 CFR § 434.6(a)(12)(i), 42 CFR § 447.26(b) and 42 CFR § 438.3(g).

15.11.2 Submit Policies and Procedures to the Department for review and approval prior to implementation of the CONTRACTOR's program.

15.11.3 Incorporate any updates made by CMS.

15.11.3.1 Updates generated by CMS are effective the date of the announcement.

15.11.4 Identify Hospital-Acquired Conditions (HACs) for non-payment as identified by Medicare and as detailed in the Department's Hospital Services Provider Manual.

15.11.5 Identify Other PPCs for non-payment, as detailed in the Department's Hospital Services Manual.

15.11.6 Require all Providers to report PPCs associated with Claims for payment or Member treatments for which payment would otherwise be made and make the information available to the Department upon request.

Section 16. DEPARTMENT RESPONSIBILITIES

16.1 Department Contract Management

The Department will be responsible for the administrative oversight of the Medicaid Managed Care Program. The management of this contract will be conducted in the best interests of the Department and the Medicaid Managed Care Members. The Department will provide clarification of the Medicaid Managed Care Program and Medicaid Policy, along with relevant regulations and Procedures.

16.1.1 All Medicaid policy decision or interpretations of this contract will be made solely by the Department and are considered final.

16.1.2 Whenever the Department is required by the terms of this contract to provide written notice to the CONTRACTOR, the Director of Department or his/her designee will sign such notice.

16.2 Payment of Capitated Rate

The CONTRACTOR shall be paid a Capitated Payment in accordance with the capitated rates specified in Appendix B, Capitation Rate(s), and Rate Methodology.

16.2.1 These rates will be reviewed and adjusted at the Department's discretion.

16.2.2 These rates shall not exceed the limits set forth in 42 CFR § 438.6(c).

16.3 Notification of Medicaid Managed Care Program Policies and Procedures

The Department will provide the CONTRACTOR with any and all updates, which include but are not limited to, appendices, information and/or interpretation of all pertinent federal and state Medicaid regulations, Medicaid Managed Care Program Policies, Procedures and guidelines affecting services under this contract.

16.3.1 The CONTRACTOR will submit written requests to the Department for additional clarification, interpretation or other information in a format specified by the Department in the Managed Care Report Companion Guide.

16.3.2 The Department's provision of such information does not relieve the CONTRACTOR of its obligation to keep informed of applicable federal and state laws related to its obligations under this contract.

16.4 Quality Assessment and Monitoring Activities

The Department is responsible for monitoring the CONTRACTOR's performance to assure compliance with this contract and the Managed Care Report Companion Guide.

16.4.1 The Department, or its designee, shall coordinate with the CONTRACTOR to establish the scope of review, the review site, relevant time frames for obtaining information, and the criteria for review.

16.4.2 On at least an annual basis, the Department, or its designee, shall inspect the CONTRACTOR's facilities, as well as audit all records developed under this contract including but not limited to periodic medical audits, Grievances, Enrollments, Disenrollments, termination, utilization and all financial records, management systems and Procedures developed or relevant to this contract.

16.4.3 The CONTRACTOR shall have the right to review any of the findings resulting from this review. However, once the Department completes its review, the CONTRACTOR must comply with all recommendations made by the Department. Failure to comply may result in liquidated damages, sanctions, Enrollment restriction, Marketing restrictions, change in the assignment algorithm, or termination of this contract.

16.5 Historical Claim Reporting to CONTRACTORs

To facilitate the treatment of Members the Department shall provide the CONTRACTOR with an updated retrospective claims history on all of the CONTRACTOR's then current Members, if available. This history will contain a maximum of twenty-four (24) months beginning from the month the Member was determined to be Eligible.

16.6 Request for Plan of Correction

The Department will monitor the CONTRACTOR's Quality of care outcome activities and corrective actions taken as specified in this contract. The CONTRACTOR must make provisions for prompt response to any detected deficiencies or contract violations and for the development of corrective action initiatives relating to this contract.

16.7 External Quality Review

The Department will perform annual, or as requested by the Department, medical audits to determine whether the CONTRACTOR furnished Quality and accessible health care to Members in compliance with 42 CFR § 438.358. The Department will contract with an External Quality Review Organization (EQRO) to perform the periodic medical audits and external independent reviews.

16.8 Marketing

The Department, and/or its designee shall have the right to deny or require modification of all Marketing plans, materials, activities, member handbooks, and Provider manuals. This includes but is not limited to social network sites, electronic media and advertisements developed by the CONTRACTOR pursuant to this contract. See *Section 12* of this contract and the Managed Care Report Companion Guide for guidance.

16.9 Grievances/Appeals

The Department shall have the right to approve, disapprove or require modification of all Grievance Procedures submitted under this contract. The Department requires the

CONTRACTOR to meet and/or exceed the Medicaid Managed Care Program Grievance standards as outlined in *Section 9* of this contract.

16.10 Training

The Department will conduct Provider training and workshops as necessary on its program Policies and Procedures.

Section 17. TERMINATION AND AMENDMENTS

This contract shall be subject to the termination provisions as provided herein. In the event of termination, it is agreed that neither party shall be relieved from any financial obligations pursuant to the contract. Medicaid Managed Care Members shall be allowed to Disenroll without cause in accordance with the Department's time frame for termination. The contract will terminate on the last day of the month of termination.

17.1 Termination under Mutual Agreement

Under mutual agreement, the Department and the CONTRACTOR may terminate this contract for any reason. Both parties will sign a notice of termination that shall include the anticipated date of termination, conditions of termination, and extent to which performance of work under this contract is terminated as required by 42 CFR § 438.710(b)(2)(ii). The CONTRACTOR will assume all incremental costs or charges associated with the termination.

17.2 Termination by Department for Breach

In the event that the Department determines that the CONTRACTOR, or any of the CONTRACTOR's Subcontractors, violated any terms of the contract and/or failed to perform its contracted duties and responsibilities in a timely and proper manner, the Department may terminate this contract pursuant to 42 CFR § 438.710(b).

17.2.1 Notice of termination for breach will specify the manner in which the CONTRACTOR or its Subcontractor(s) has failed to perform its contractual responsibilities.

17.2.2 If the Department determines that the CONTRACTOR and/or its Subcontractor(s) have satisfactorily implemented corrective action within the thirty (30) Calendar Day notice period, the notice of termination may be withdrawn at the discretion of the Department.

17.2.3 The Department may withhold any monies due the CONTRACTOR pending final resolution of termination of the contract.

17.2.4 If damages to the Department exceed payment due to the CONTRACTOR, collection can be made from the CONTRACTOR's fidelity bond, errors and omissions insurance, or any insurance policy required under this contract. In addition, CONTRACTOR may pay any sums directly without a bond or insurance Claim.

17.2.5 The Department further reserves the right to any additional rights and remedies provided by law or under this contract.

17.3 Termination for Unavailability of Funds

In the event that federal and/or state funds to finance this contract become unavailable after the effective date of this contract, or prior to the anticipated expiration date of this contract, the Department may terminate this contract without penalty.

17.3.1 The Department shall notify the CONTRACTOR in writing of a termination for unavailability of funds.

17.3.2 Availability of funds shall be determined solely by the Department.

17.4 Termination for CONTRACTOR Insolvency, Bankruptcy, Instability of Funds

The CONTRACTOR's Insolvency or the filing of a petition in bankruptcy by or against the CONTRACTOR shall constitute grounds for termination of this contract for cause.

17.4.1 If SCDOI and/or the Department determine the CONTRACTOR has become financially unstable and/or the CONTRACTOR's license is revoked, the Department will terminate this contract.

17.5 Termination by the CONTRACTOR

The CONTRACTOR may, at its option, terminate this contract:

17.5.1 The CONTRACTOR shall give the Department written notice of intent to terminate this contract one hundred twenty (120) Calendar Days prior to the CONTRACTOR’s intended last date of operation.

17.5.1.1 The Department shall determine the CONTRACTOR’s final date of operation based on the written notice of intent to terminate and existing Department priorities.

17.5.2 The CONTRACTOR shall comply with all terms and conditions stipulated in this contract during the termination period.

17.5.3 In the event of a termination by the CONTRACTOR, the CONTRACTOR will pay any costs or charges incurred by the Department, its Enrollment broker, or Providers as a result of such a termination.

17.6 Termination for Loss of Licensure or Certification

In the event the CONTRACTOR loses its license issued by the South Carolina Department of Insurance (SCDOI) or any other appropriate licensing agency to operate or practice in South Carolina, the Department shall terminate this contract. Further, should the CONTRACTOR lose its certification to participate in the Title XVIII and/or Title XIX Program, the Department shall terminate this contract.

17.6.1 CONTRACTOR shall pay any costs or charges incurred by the Department, its Enrollment broker, or Providers as a result of a termination due to the loss of licensure or certification.

17.7 Termination for Noncompliance with the Drug Free Workplace Act

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

17.7.1 The CONTRACTOR shall pay any costs or charges incurred by the Department, its Enrollment broker, or Providers as a result of such a termination.

17.8 Termination for Actions of Owners/Managers

This CONTRACT is subject to termination, unless the CONTRACTOR can demonstrate changes of ownership or control, when a person with a direct or indirect ownership interest with the CONTRACTOR:

17.8.1 Actions

17.8.1.1 Has been Convicted of a criminal offense under 42 CFR §§ 1128(a), 1128(b)(1), or 1128(b)(3) of the Social Security Act, in accordance with 42 CFR § 1002.203;

17.8.1.2 Has had civil monetary penalties or assessments imposed under § 1128A of the Social Security Act; or

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

And,

17.8.2 Owners/Managers

17.8.2.1 Has a direct or indirect ownership interest or any combination therefore of five percent (5%) or more, is an officer if the CONTRACTOR is organized as a corporation or partnership, or is an agent or a managing employee, and/or

17.8.2.2 The CONTRACTOR has a direct or indirect substantial contractual relationship with an excluded individual or entity. “Substantial Contractual Relationship” is defined as any direct or indirect business transactions that amounts to more than twenty-five thousand ($25,000) or five percent (5%) of the CONTRACTOR’s total operating expenses in a single fiscal year, whichever is less.

17.9 Non-Renewal

This contract shall be renewed only upon mutual consent of the parties. Either party may decline to renew the contract for any reason. However, should either party fail to provide notice of non-renewal to the other party within ninety (90) Calendar Days of the end date of this contract, this contract may be extended at the discretion of the Department for the purpose of reassigning Members enrolled in the CONTRACTOR’s Health Plan and terminating the CONTRACTOR as a MCO.

17.10 Termination Process

Upon receipt of a notice of termination by the CONTRACTOR, the issuance of a notice of termination by the Department, or the entry of both parties into a notice of termination by mutual agreement, the CONTRACTOR shall develop a project plan that outlines the steps to effectuate the termination of the CONTRACTOR as a Medicaid Managed Care Organization and the reassignment of Medicaid Managed Care Members to other CONTRACTOR's Health Plans. This project plan must include anticipated dates for the completion of necessary tasks; and when the termination will be effective; and must be provided to the Department within ten (10) Business Days from the date of the notice of termination for review and approval.

Prior to its issuance of a notice of termination, the Department will provide the CONTRACTOR with written notice of its intent to terminate, the reason for termination, and the time and place of the pre-termination hearing. After the hearing, the Contractor will be given written notice of the decision to affirm or reverse the proposed termination of this Contract, and if affirmed, the effective date of such termination.

Subject to the provisions stated herein, after the notice of termination has been submitted (whether related to one part of the CONTRATOR's Service Area of this entire contract), the CONTRACTOR shall:

17.10.1 Continue to provide services under the contract, until the effective date of the termination.

17.10.2 Immediately terminate all Marketing Procedures and Subcontracts related to marketing.

17.10.3 Maintain Claims processing functions as necessary for a minimum of twelve (12) months after the date of termination (or longer if it is likely there are additional Claims outstanding) to complete adjudication of all Claims.

17.10.4 Remain liable and retain responsibility for all Claims with dates of service through the date of termination.

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

17.10.6 Be financially responsible for services rendered prior to the termination date, for which payment is initially denied by the CONTRACTOR and subsequently approved by the CONTRACTOR during the Provider dispute resolution process.

17.10.7 Be financially responsible for Member Appeals of adverse decisions rendered by the CONTRACTOR concerning treatment requested prior to the termination date which are subsequently determined in the Member's favor after an Appeal proceeding or a state fair hearing.

17.10.8 Assist the Department with Grievances and Appeals for dates of service prior to the termination date.

17.10.9 Arrange for the orderly transfer of patient care and patient records to those Providers who will assume Members' care.

17.10.9.1 For those Members in a course of treatment for which a change of Providers could be harmful, the CONTRACTOR must continue to provide services until that treatment is concluded or appropriate transfer of care can be arranged.

17.10.10 Notify all Members in writing about the termination of this contract and the process by which Members will continue to receive medical care at least sixty (60) Calendar Days in advance of the effective date of termination as specified 42 CFR §§ 438.710(b)(2)(iii), 438.10 and 438.722.

17.10.10.1 The CONTRACTOR will be responsible for all charges or costs associated with Member notification.

17.10.10.2 The Department must approve all Member notification materials prior to distribution.

17.10.10.3 Such notice must include a description of alternatives available for obtaining services after termination of this contract.

17.10.11 Terminate all Subcontracts with all health care Providers to correspond with the termination of this contract at least sixty (60) Calendar Days in advance of the effective date of termination.

17.10.11.1 The CONTRACTOR will be responsible for all expenses associated with Provider notification. The Department must approve all Provider notification materials prior to distribution.

17.10.12 Take all actions necessary to ensure the efficient and orderly transition of Members from coverage under this contract to coverage under any new arrangement authorized by the Department, including any actions required by the Department to complete the transition of members and the termination of CONTRACTOR as an MCO.

17.10.12.1 Such actions to be taken by the CONTRACTOR shall include, but are not limited to, the forwarding of all medical or financial records related to the CONTRACTOR's activities undertaken pursuant to this contract; facilitation and scheduling of medically necessary appointments for care and services; and identification of chronically ill, high risk, hospitalized, and pregnant Members in their last four (4) weeks of pregnancy.

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

17.10.14 Ensure fulfillment of its obligations before and after termination, maintain the financial requirements, fidelity bonds and insurance set forth in this contract until the Department provides the CONTRACTOR written notice that all obligations of this contract have been met.

17.10.15 Be responsible for all financial costs associated with its termination, including, but not limited to costs associated with changes to the Enrollment broker's website, computer system, mailings, and all communications between the Department and the Enrollment broker to the CONTRACTOR's Members regarding their choice period and any additional changes after the termination effective date.

17.10.16 If applicable, assign to the Department in the manner and extent directed by the Department all rights, title, and interest of the CONTRACTOR for the performance of the Subcontracts as needed.

17.10.16.1 The Department shall have discretion, to resolve or pay any of the Claims arising out of the termination of Subcontracts.

17.10.16.2 The CONTRACTOR shall supply all information necessary for the reimbursement of any outstanding Medicaid Claims.

17.10.17 Take any action necessary, for the protection of property related to this contract in possession of the CONTRACTOR in which the Department has or may acquire an interest.

17.10.18 In the event the Department terminates the contract, the CONTRACTOR must continue to serve or arrange for provision of services to the Members of the CONTRACTOR until the effective date of termination.

17.10.18.1 During this transition period, the Department shall continue to pay the applicable Capitation Payment.

17.10.18.2 Members shall be given written notice of the State's intent to terminate this contract and shall be allowed to Disenroll immediately without cause.

17.10.19 Promptly supply all information necessary to the Department or its designee for reimbursement of any outstanding Claims at the time of termination.

17.10.20 Any payments due under the terms of this contract may be withheld until the Department receives from the CONTRACTOR all written and properly executed documents and the CONTRACTOR complies with all requests of the Department related to this contract.

17.11 Amendments and Rate Adjustments

This contract may be amended at any time as provided in this Section of this contract.

17.11.1 Amendment due to Change in Law, Regulation, or Policy

Any provision of this contract that conflicts with federal statutes, regulations, an applicable waiver, SPA, or CMS policy guidance is hereby amended to conform to the provisions of those laws, regulations, and federal Policies.

Such amendment of the contract will be effective on the date of the statute, regulation, or policy statement necessitating amendment, and will be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

17.11.1.1 The Department shall notify the CONTRACTOR regarding such changes and this contract shall be automatically amended to conform to such changes without necessity for executing written amendments.

17.11.2 Amendment by Mutual Agreement

This contract may be amended upon mutual agreement of the parties. Such amendment must be in writing and signed by the CONTRACTOR and the Department and incorporated as a written amendment to this contract prior to the effective date of such modification or change. Any amendment to this contract shall require approval by the CMS regional office.

17.11.3 Rate Adjustments

17.11.3.1 The CONTRACTOR and Department both agree that the Capitation Payment identified in Appendix B of this contract shall remain in effect during the period identified in the annual rate certification. Rates may be adjusted during the contract period based on Department and actuarial analysis, and subject to CMS review and approval.

17.11.3.2 The CONTRACTOR and Department both agree the adjustments to the Capitation Payment(s) required pursuant to this Section of the contract shall occur only by written amendment to this contract. The CONTRACTOR will have seven (7) Calendar Days to execute the rate amendment. Should the CONTRACTOR fail to

do so the Department may at its discretion impose a fine equal to one thousand five hundred dollars ($1,500) per day and/or terminate the contract.

Section 18. AUDITS, FINES AND LIQUIDATED DAMAGES

18.1 Audit

18.1.1 The CONTRACTOR must undergo a performance audit conducted by the Department or its designee at least once every three (3) years to determine the following:

18.1.1.1 Compliance with this contract,

18.1.1.2 The effectiveness of the CONTRACTOR's program integrity and special investigation unit (SIU) activities,

18.1.1.3 Compliance with all applicable federal requirements for Program integrity,

18.1.1.4 Accuracy and reliability of Encounter data and any other information required to be reported by the CONTRACTOR,

18.1.1.5 Compliance with TPL rules,

18.1.1.6 Compliance with Department payment rules, and

18.1.1.7 Effectiveness of the CONTRACTOR's process for handling member and Provider Grievances and complaints.

18.1.2 The Audit may include a review for Fraud and Abuse on the part of the CONTRACTORs, such as:

18.1.2.1 Contract procurement Fraud (Provider credentials, financial solvency, inadequate network, bid rigging)

18.1.2.2 Marketing and Enrollment Fraud (slamming, enrolling ineligible or non-existent members, cherry-picking, kickbacks, lemon-dropping)

18.1.2.3 Underutilization (delays, denials, unreasonable Prior Authorization requirements, gag orders to Providers)

18.1.2.4 Claims submission and billing Fraud (misrepresenting Medical Loss Ratios (MLRs), Dual Eligible scams, cost-shifting to carve-outs, misrepresenting kicker payment-eligible services or incentivized services, Encounter data Fraud)

18.1.3 These audits may be conducted using either internal audit and/or contracted audit staff and will be conducted in accordance with Generally Accepted Governmental Auditing Standards. The Department will be responsible for developing the scope and protocols for the audit.

18.1.4 Audit findings of non-compliance on the part of the CONTRACTOR may be addressed through Corrective Action Plans and sanctions up to and including liquidated damages as specified in this contract. Nothing in this requirement is intended to duplicate or forestall any other audits of the CONTRACTOR required by this contract, the SC Department of Insurance (SCDOI), national standards, or CMS.

18.2 Corrective Action Plan (CAP)

The CONTRACTOR and its Subcontractors shall comply with all requirements of this contract. In the event the Department or its designee finds that the CONTRACTOR and/or its Subcontractors failed to comply with any requirements of this contract, the CONTRACTOR shall be required to submit a plan of correction to the Department outlining the steps to correct any deficiencies and/or non-compliance issues identified by Department along with criteria for interim milestones to be achieved, which may include, but is not limited to, reporting objectives, schedule, and staffing commitment. The plan of correction must provide sufficient detail for the Department to determine the appropriateness and effectiveness of the plan.

18.2.1 The Department will provide written notification to a CONTRACTOR when the CONTRACTOR is placed under a CAP.

18.2.2 The Department may make a public announcement when it places the CONTRACTOR under a CAP.

18.2.2.1 The announcement will, at a minimum, be made via Provider bulletin, media release and/or publication on the Department's web site. The CONTRACTOR's plan of correction shall be submitted to Department within the time frame specified in the notice of corrective action.

18.2.3 The Department shall have final approval of the CONTRACTOR's plan of correction.

18.2.3.1 The CAP must include a date certain for correction of the issues leading to the occurrence along with interim milestones to be achieved, the criteria for determining that a milestone has been achieved, reporting objectives and schedule, staffing commitment and sufficiently detailed description for the Department to determine the appropriateness and effectiveness of the plan of correction.

18.2.3.2 Issues not substantially corrected by the dates agreed upon in the plan of correction will result in the original schedule of damages being reinstated, including collection of damages for the corrective action period, and liquidated damages will continue until

satisfactory correction of the occurrence, as determined by the Department.

18.2.4 The CONTRACTOR and/or its Subcontractor(s) shall implement the corrective actions as approved by the Department and maintain compliance with time frames specified in the notice of corrective action and all contract requirements.

18.2.4.1 The CONTRACTOR and/or its Subcontractors shall be available and cooperate with the Department and/or its designee as needed in implementing the approved corrective actions.

18.2.4.2 Failure of the CONTRACTOR and/or its Subcontractor(s) to implement the Corrective Action Plan as approved by the Department shall subject the CONTRACTOR to the actions, stated in this contract including all subsections of this contract.

18.2.5 Whenever the Department determines, based on identified facts and documentation, the CONTRACTOR is failing to meet material obligations and performance standards described in this contract, the Department may suspend the CONTRACTOR's right to enroll Members and impose any other sanctions and/or liquidated damages available to the Department by state or federal statute or regulation or the terms of this contract.

18.2.5.1 The Department, when exercising this option, shall notify the CONTRACTOR in writing its intent to suspend Enrollment. The suspension period may be for any length of time specified by the Department, not to exceed the CONTRACTOR’s completion of a CAP. The Department also may notify Members of the CONTRACTOR’s non-performance and permit these Members to transfer to another Health Plan following the implementation of suspension.

18.3 Sanctions

If the Department determines the CONTRACTOR has violated any provision of this contract, or the applicable statutes or rules governing Medicaid prepaid health plans, the Department may impose sanctions against the CONTRACTOR.

The Department shall notify the CONTRACTOR and CMS in writing of its intent to impose sanctions along with an explanation of CONTRACTOR’s due process rights. Unless the duration of a sanction is specified, a sanction will remain in effect until the Department is satisfied that the basis for imposing the sanction has been corrected. The Department will notify CMS when a sanction has been lifted.

Sanctions shall be in accordance with 42 CFR §§ 438 Subpart I- Sanctions and may include any of the following:

18.3.1 Suspension of payment for Recipients enrolled after the effective date of the sanction and until CMS or the Department is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur. This violation may result in Recoupment of the Capitated Payment.

18.3.2 Suspension of all Marketing activities permitted under this contract.

18.3.3 Imposition of a fine of up to twenty-five thousand dollars ($25,000.00) for each marketing/Enrollment violation, in connection with any one audit or investigation.

18.3.4 Termination pursuant to *Section 17* of this contract.

18.3.5 Non-renewal of the contract pursuant to *Section 17* of this contract.

18.3.6 Suspension of auto-Enrollment.

18.3.7 Appointment of temporary management in accordance with § 1932(e)(2)(B) of SSA (42 U.S.C. 1396u-2) (2001, as amended) and 42 CFR § 438.702. If the State finds that the CONTRACTOR has repeatedly failed to meet substantive requirements in § 1903(m) or § 1932 of the Social Security Act (42 USC 1396u-2), the State must impose temporary management, and notify members of their right to terminate Enrollment without cause;

18.3.8 Civil money penalties in accordance with § 1932 of the Social Security Act (42USC 1396u-2);

18.3.9 Withholding of a portion or all of the CONTRACTOR's Capitation Payment.

18.3.10 Permitting individuals enrolled in the CONTRACTOR's Plan to Disenroll without cause. Department may suspend or default all Enrollment of Members after the date the secretary or Department notifies the CONTRACTOR of an occurrence under § 1903(m) or § 1932(e) of the Social Security Act.

18.3.11 Terminating the contract if the CONTRACTOR has failed to meet the requirements of Sections 1903(m), 1905(t)(3) or 1932(e) of the Social Security Act and offer the CONTRACTOR's Members an opportunity to enroll with other CONTRACTORs to allow Members to receive medical assistance under the South Carolina State Plan for Medical Assistance. The Department shall provide the CONTRACTOR an opportunity for a hearing before the Department's Division of Appeals and Hearings prior to termination. The Department will notify the Members enrolled in the CONTRACTOR's Health Plan of the hearing and the Member's option for receiving services following the date of termination including the Members option to Disenroll, without cause;

18.3.12 Imposition of sanctions pursuant to § 1932(e)(B) of the Social Security Act if the CONTRACTOR does not provide abortion services as specified under the contract at *Section 4*.

18.3.13 Imposition of a fine of up to twenty-five thousand dollars ($25,000) for each occurrence of the CONTRACTOR's failure to substantially provide Medically Necessary items and services that are required to be provided to a Member covered under the contract and for misrepresentation or false statements to Members, potential Members or health care Providers for failure to comply with Physician incentive plans or Marketing violations, including direct or indirect distribution by the CONTRACTOR, its agent or independent CONTRACTOR of Marketing Materials that have not been approved by the State or that contain false or materially misleading information;

18.3.14 Imposition of a fine of up to fifteen thousand dollars ($15,000) per individual not enrolled and up to a total of one hundred thousand dollars ($100,000) per occurrence, when the CONTRACTOR acts to discriminate among Members on the basis of their health status or their requirements for health care services. Such discrimination includes, but is not limited to, expulsion or refusal to re-enroll an individual, except as permitted by Title XIX, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging Enrollment with the entity by Eligible individuals whose medical condition or history indicates a need for substantial future medical services;

18.3.15 Imposition of a fine as high as double the excess amount charged to the Members by the CONTRACTOR for premiums or charges in excess of the premiums or charges permitted under Title XIX. In this instance, the Department will deduct the amount of the overcharge from the penalty and return it to the affected Member.

18.3.16 Imposition of sanctions if the CONTRACTOR fails to comply with the Physician Incentive Plan requirements. 18.3.17 Imposition of sanctions as outlined above and to include a civil monetary penalty of up to $100,000 for each instance of misrepresentation if the CONTRACTOR misrepresents or falsifies information it furnishes to CMS, the State or to an actual or potential Member, or Provider.

18.4 Liquidated Damages for Failure to Meet Contract Requirements

The Department and the CONTRACTOR agree that in the event of the CONTRACTOR's failure to meet the requirements provided in this contract and/or all documents incorporated herein, and the extent of damages sustained by the Department is unascertainable the CONTRACTOR shall be liable to the Department for liquidated damages in the fixed amounts stated in this Section of this contract.

18.4.1 It is also agreed that the collection of liquidated damages by the Department shall be made without regard to any Appeal rights the CONTRACTOR may have pursuant to this contract.

18.4.2 The CONTRACTOR shall pay the Department liquidated damages in the amount of up to one thousand five hundred dollars ($1,500.00) per day or up to ten

thousand dollars per incident ($10,000.00) of noncompliance with any requirement stated in this Contract and/or all documents incorporated herein. The Department retains the discretion to choose the per-day or per incident damages, taking into consideration the facts and circumstances surrounding CONTRACTOR's noncompliance.

18.4.2.1 Liquidated damages for noncompliance with specific contract requirements identified in *Exhibit 7* are listed therein and supersede the general liquidated damages provision stated herein.

18.4.3 The CONTRACTOR shall not be liable for liquidated damages if the CONTRACTOR would have been able to meet the contract requirement but for the Department's failure to perform as provided in this Contract.

18.4.4 In the event an Appeal by the CONTRACTOR regarding the application of liquidated damages under this contract results in a decision in favor of the CONTRACTOR, any such funds paid by the CONTRACTOR or withheld by the Department shall be returned to the CONTRACTOR less any cost incurred by the Department.

18.4.5 Any liquidated damages assessed by the Department shall be due and payable to the Department within thirty (30) Calendar Days after the Department issues a notice of assessment. If payment is not made by that date, the Department shall withhold the amount due from future monthly Capitation Payment(s).

18.4.6 After appeal, the Department reserves the right to publish information regarding the application of liquidated damages, in accordance with Department transparency initiatives.

Exhibit 7. Liquidated Damages by Performance Measure, Frequency and Damage

Section No.	PERFORMANCE MEASURE	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
2	CONTRACTOR's staff must include but is not limited to the Key Personnel listed in Exhibit 1.	Daily	The Department is entitled to assess up to $5,000 per occurrence.[1]
2	CONTRACTOR shall notify the Department in writing of any changes in Key Personnel.	Daily	The Department is entitled to assess up to $5,000 per occurrence.
2	CONTRACTOR shall follow Department policy on Credentialing/re-Credentialing of In Network Providers.	Varies by Provider type	The Department is entitled to assess up to $5,000 per occurrence.[3]
2	CONTRACTOR shall submit each new In Network Provider template prior to execution of the agreement.	As Updated	The Department is entitled to assess up to $5,000 per occurrence.
2	Completely process Credentialing applications within sixty (60) Calendar Days of receipt of a completed Credentialing application, including all necessary documentation and attachments, and a signed contract/agreement if applicable. Completely process shall mean that the CONTRACTOR shall review, approve, and load approved Applicants to its Provider files in its Claims processing system or deny the application and assure that the Provider is not used by the CONTRACTOR.		The Department is entitled to assess an amount up to $500 per occurrence.

Section No.	PERFORMANCE MEASURE	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
3	Reissue the Member ID card within fourteen (14) Days after notice by a member of a lost card, a change in the member's PCP, or for any other reason that results in a change to the information on the Member ID card		The Department is entitled to assess up to $250 per occurrence.
3	CONTRACTOR shall maintain a call center that complies with all Service Level Agreements specified in the contract Section.	Daily/Monthly	The Department is entitled to assess up to $1,500 per day.
3	Failure of CONTRACTOR to adhere to any and all appeal and grievance timeframes specified in this Contract		For quarterly submissions of grievances and appeals, if the report has greater than ten > (10) findings, the Department may assess damages in an amount up to $10,000 per report.
4	CONTRACTOR shall implement a member pharmacy lock-in Program to monitor member's use of prescription drugs.	Daily	The Department is entitled to assess up to $5,000 per day.
4	Negative PDL changes must be published on the CONTRACTORs website and communicated to the Department at least thirty (30) Days prior to implementation		The Department is entitled to assess an amount up to $500 per occurrence.
6	CONTRACTOR must be able to provide Primary Care Services by a contracted Provider within the time and distance requirements of the contract.	Daily	The Department is entitled to assess up to $5,000 per occurrence.[4]
6	CONTRACTOR shall comply with the stated timelines for submission of network adequacy reports.	Periodically	The Department is entitled to assess up to $10,000 per day for late submissions.

Section No.	PERFORMANCE MEASURE	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
7	CONTRACTOR shall pay 90% of Clean Claims within thirty (30) Days of Claim receipt.	Daily	The Department is entitled to assess up to $5,000 per day.
7	CONTRACTOR shall pay 99% of Clean Claims within ninety (90) Days of Claim receipt.	Daily	The Department is entitled to assess up to $5,000 per day.
11	CONTRACTOR must immediately report any suspicion or knowledge of FWA by its Medicaid Managed Care Members, employees, or Subcontractors.	Daily	The Department is entitled to assess up to $10,000 per occurrence.
11	CONTRACTOR must comply with provisions prohibiting payments to excluded and/or terminated Providers.	Periodic	The Department is entitled to assess up to $10,000 per occurrence.
14	CONTRACTOR must submit Encounter data for paid services to the Department.		The Department is entitled to assess up to $10,000 per occurrence for missed submissions.
14	CONTRACTOR's Encounter submission must be at least 97% accurately submitted by total and claim type.		The Department is entitled to assess up to $10,000 per occurrence for submissions that are below 97%.
14	The CONTRACTOR must correct and resubmit all previously denied Encounter records within ninety (90) days after initial submission.		The Department is entitled to assess up to $10,000 per occurrence for submissions that are between 97% and 100%.
14	Encounter Quality Initiative (EQI) reports are due within one hundred and twenty-one (121) Days of the end of each calendar quarter.	Quarterly	The Department is entitled to assess up to $10,000 per occurrence for missed submissions.

Section No.	PERFORMANCE MEASURE	MEASUREMENT FREQUENCY	LIQUIDATED DAMAGE
15	CONTRACTOR must achieve at least the minimum performance standard per Quality index as defined in the Managed Care Process and Procedure Manual.	Annually	The Department is entitled to assess up to $500,000 for each index that fails to meet the standard identified in the Managed Care Process and Procedure Manual.
19	The CONTRACTOR and its Subcontractors must develop, implement, maintain, and use appropriate safeguards to prevent any use or disclosure of the PHI or EPHI other data, as outlined within various Sections of this contract (e.g., Section 19, Appendix C).		Imposition of a fine of up to $1,000 per Member impacted by the breach on a per-breach basis.
C	Negligent breach in privacy or security that compromises PHI other than as permitted or required by the contract or as required by law.		The Department may impose a fine of $300 per day from the date that the Business Associate knew or should have known of any breach in privacy or security that compromises PHI to the date the Department becomes aware of the breach.
C	Negligent breach in privacy or security that compromises PHI other than as permitted or required by the contract or as required by law.		The Department is entitled to assess up to $25,000 per occurrence.

[1] For each vacant position.

[2] For each change in position that did not include a notification to the Department.

[3] For each instance of a violation to a Credentialing and/or re-Credentialing of an In Network Provider.

[4] For each instance of a violation to Section 6.2.2.1 of this contract—that being (i) the CONTRACTOR's inability to provide access to at least one (1) PCP with an open panel within thirty (30) miles of a member's place of residence; and/or (b) the CONTRACTOR's inability to ensure that its contracted primary care Providers have an appointment system that meets the access standards listed within Section 6.2.2.1 of this contract.

Section 19. TERMS AND CONDITIONS

19.1 General Contractual Condition

The CONTRACTOR agrees to comply with all state and federal laws, regulations, and Policies as they exist as of the date of this contract, or as later amended that are or may be applicable to this contract, including those not specifically mentioned herein.

19.2 HIPAA Compliance

The CONTRACTOR agrees that it shall comply with Title II, Subtitle F, Section 261-264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191, titled "Administrative Simplification" and the rules and regulations promulgated thereunder. In addition, the Contractor will ensure compliance with all HIPAA requirements across all systems and Services related to this Contract, including transaction, common identifier, and privacy and security standards, by the effective date of those rules and regulations. The Contractor will comply with the rules and regulations and will implement these rules and regulations to achieve consistency in data collection, validation, storage, retrieval, and consolidation with all SCDHHS' programs.

19.3 HIPAA Privacy and Security

CONTRACTOR shall comply with the HIPAA Privacy Rule and Security Rule. Contractor shall ensure applicable standards for privacy of individually identifiable health information (Privacy Rule) and adequate controls for the protection of electronic protected health information (Security Rule) are effective and remain in place during the term of this Contract pursuant to 42 CFR § 438.208(b)(6), 42 CFR § 438.224, 45 CFR § 160, and 45 CFR § 164 .

19.4 HIPAA Business Associate

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

19.5 Safeguarding Information

The CONTRACTOR shall establish written safeguards that restrict the use and disclosure of information concerning Members or potential members to purposes directly connected with the performance of this contract. The CONTRACTOR's written safeguards shall:

19.5.1 Operate systems and provide Services compliant with the current version of the CMS MARS-E Catalog of Minimum Acceptable Risk Security and Privacy Controls for Exchanges, or the most current release of CMS' security and privacy control catalog and/or framework, as well as current HIPAA regulations. Be at least as restrictive as those imposed by 42 CFR § Part 431, Subpart F (2009, as amended) and S.C. Code Regs. § 126-170 et seq. (Supp. 2009, as amended);

19.5.2 State that, in the event of a conflict between the CONTRACTOR's written safeguard standards and any other state or federal confidentiality statute or regulation, the safeguards shall be at least as restrictive as those imposed by 42 CFR § Part 431, Subpart F (2009, as amended) and S.C. Code Regs. § 126-170 et seq. (Supp. 2009, as amended). CONTRACTOR shall apply the stricter standard;

19.5.3 All government data, to include Protected Health Information, shall be encrypted in transit (when sent over an unsecured, untrusted network, to include sent over email) and at rest. Any government data or Protected Health Information stored on portable devices must be encrypted. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, portable hard or removable hard drives, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, smartphones (such iPhones, Android, Blackberry, or other type devices), cell phones, portable audio/video devices (such as iPod, and MP3 and MP4 players), and personal organizers. Safeguarding of information shall be in accordance with applicable state and federal laws and regulations and shall restrict access to, and use and disclosure of, such information in compliance with said laws and regulations;

19.5.4 Require the written consent of the Member or potential member before disclosure of information about him or her, except in those instances where state or federal statutes or regulations require disclosure or allow disclosure with the consent of the Member or potential Member;

19.5.5 Only allow the public release of statistical or aggregate data that has been de-identified in accordance with federal regulations at 45 CFR § 164.514 and which cannot be traced back to particular individuals;

19.5.6 Ensure that all Member data containing protected health information (PHI), as defined by HIPAA, is secured through commercially reasonable methodology in compliance with HITECH. This includes, but is not limited to, the following requirements and associated penalties:

19.5.6.1 Member PHI data protection and safeguards require the CONTRACTOR to employ practices that ensure such data is rendered unusable, unreadable and indecipherable to unauthorized individuals through encryption or destruction, that compromises the security or privacy of Member PHI

19.5.6.2 Immediately upon discovery of a compromise or improper use of Member PHI/PII, Contractor shall take such action as may be necessary to preserve forensic evidence and eliminate the cause of the compromise or improper use. As soon as practicable, but no later than twenty-four (24) hours after discovery, Contractor shall notify the Department of the compromise or improper use, including a description of the circumstances of the use or

compromise. As soon as practicable after discovery, Contractor shall undertake a thorough forensic investigation of any compromise or improper use of Member PHI/PII and provide the Department all information necessary to enable the Department to fully understand the nature and extent of the compromise or improper use. With regard to any compromise or improper use of Member PHI/PII, Contractor shall: (1) provide any notification to third parties legally required to be provided such notice by Contractor, and if not (e.g., if legally required of the using governmental unit), Contractor shall reimburse the Department for the cost of providing such notifications; (2) pay all costs and expenses for at least two years of identity theft monitoring services (including without limitation, credit monitoring) and identity theft restoration services for any such affected individuals receiving notice where such services are appropriate given the circumstances of the incident and the nature of the information compromised; (3) undertake any other measures that are customary and reasonable for an entity to take when experiencing a similar disclosure, (4) pay any related fines or penalties imposed on the Department, and (5) reimburse the Department all costs reasonably incurred for communications and public relations services involved in responding to the compromise or improper use of Member PHI/PII. Notwithstanding any other provision, contractor's obligations pursuant to this item (19.4.5.2) are without limitation. (See Appendix C for additional requirements and penalties associated with data breaches and Member PHI protection standards, violations and damages),

19.5.6.3 If the Department deems credit monitoring and/or identity theft safeguards are needed to protect the Members whose PHI was placed at risk by the CONTRACTOR's failure to comply with the terms of this contract, the CONTRACTOR shall be liable for all costs associated with the provision of such monitoring and/or safeguard services, and

19.5.6.4 Imposition of a fine of up to One Thousand Dollars ($1,000) per Member impacted by the breach on a per-breach basis.

19.5.7 Specify appropriate personnel actions to sanction violators.

19.6 Release of Records

The CONTRACTOR shall release Health Records of Members, as authorized by the member, or as directed by authorized personnel of the Department, appropriate state

agencies, or the United States government. Release of Health Records shall be consistent with the provisions of confidentiality as expressed in this contract.

19.7 Confidentiality of Information

The CONTRACTOR shall assure all material and information, which is provided to or obtained by or through the CONTRACTOR's performance under this contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent such treatment is required under state or federal regulations or statutes.

19.7.1 The CONTRACTOR shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this contract.

19.7.2 All information as to personal facts and circumstances concerning members or potential members obtained by the CONTRACTOR shall be treated as privileged and confidential communications, and shall not be provided to another party without written consent of the Department or the Member/potential Member. However, nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Members/potential Members shall be limited to purposes directly connected with the administration of this contract.

19.8 Integration

This contract shall be construed to be the complete integration of all understandings between the parties hereto. No prior or contemporaneous addition, deletion, or other amendment shall have any force or effect unless embodied in writing. No subsequent novation, renewal, addition, deletion, or other amendment shall have any force or effect unless embodied in a written amendment executed and approved by the parties.

19.9 Hold Harmless

The CONTRACTOR shall indemnify, defend, protect, and hold harmless the Department and any of its officers, agents, and employees from:

19.9.1 Any Claims for damages or losses arising from services rendered by any Subcontractor, person, or firm performing or supplying services, materials, or supplies for the CONTRACTOR in connection with the performance of this contract;

19.9.2 Any Claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by CONTRACTOR, its agents, officers, employees, or Subcontractors in the performance of this contract;

19.9.3 Any Claims for damages or losses resulting to any person or firm injured or damaged by CONTRACTOR, its agents, officers, employees, or Subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this contract in a manner not authorized by the contract or by federal or state regulations or statutes;

19.9.4 Any failure of the CONTRACTOR, its agents, officers, employees, or Subcontractors to observe the federal or state laws and regulations, including, but not limited to, labor laws and minimum wage laws;

19.9.5 Any Claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of Department in connection with the defense of Claims for such injuries, losses, Claims, or damages specified above;

19.9.6 Any injuries, deaths, losses, damages, Claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against Department or their agents, officers or employees, through the intentional conduct, negligence or omission of the CONTRACTOR, its agents, officers, employees or Subcontractors.

19.9.7 In the event due to circumstances not reasonably within the control of CONTRACTOR or Department, (i.e., a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither the CONTRACTOR, Department, or Subcontractors(s), will have any liability or obligation on account of reasonable delay in the provision or the arrangement of Covered Services; provided, however, that so long as the CONTRACTOR's certificate of authority remains in full force and effect the CONTRACTOR shall be liable for the Covered Services required to be provided or arranged for in accordance with this contract.

19.10 Hold Harmless as to the Medicaid Managed Care Program Members

In accordance with the requirements of S.C Code Ann. § 38-33-130(b) (Supp. 2001, as amended), 42 CFR § 438.106(a)-(c), 42 CFR § 438.3(k), 42 CFR § 438.230, section 1932(b)(6) of the Act and as a condition of participation as a health care Provider, the CONTRACTOR hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, Medicaid Managed Care Members of the CONTRACTOR, or persons acting on their behalf, for health care services which are rendered to such members by the CONTRACTOR and its Subcontractors, and which are covered Benefits under the members Evidence of Coverage. This provision applies to all covered health care services furnished to the Member for which the State does not pay the CONTRACTOR or the State or the CONTRACTOR does not pay the individual or health care Provider that furnishes the services under a contractual, referred, or other arrangement during the time the member is enrolled in, or otherwise entitled to Benefits promised by the CONTRACTOR.

The CONTRACTOR further agrees that the Member shall not be held liable for payment for Covered Services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the member would owe if the Department provided the service directly. The CONTRACTOR agrees that this provision is applicable in all circumstances including, but not limited to, non- payment by CONTRACTOR and Insolvency of CONTRACTOR. The CONTRACTOR further agrees that this provision shall be construed to be for the benefit of Medicaid Managed Care Members of CONTRACTOR, and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the CONTRACTOR and such members, or persons acting on their behalf.

19.11 Notification of Legal Action

The CONTRACTOR shall give the Department notification in writing by certified mail within five (5) Business Days of being notified of any administrative legal action or complaint filed and prompt notice of any claim made against the CONTRACTOR by a Subcontractor or Member which may result in litigation related in any way to this contract.

19.12 Non-Discrimination

The CONTRACTOR agrees that no person, on the grounds of age, race, color, national orientation, religion, sex, sexual orientation, gender identity, or disability or shall be excluded from participation, or be denied Benefits of the CONTRACTOR's MCO Program or otherwise subjected to discrimination in the performance of this contract or in the employment practices of the CONTRACTOR. The CONTRACTOR shall upon request show proof of such non-discrimination, and shall post in conspicuous places, available to all employees and Applicants, notices of non-discrimination. This provision shall be included in all Subcontracts.

19.13 Safety Precautions

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

19.14 Loss of Federal Financial Participation (FFP)

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

19.15 Sharing of Information

The CONTRACTOR understands and agrees that Department and SCDOI may share any and all documents and information, including confidential documents and information, related to compliance with this contract and any and all South Carolina insurance laws applicable to Health Maintenance Organizations (HMO). The CONTRACTOR further understands and agrees that the sharing of information between the Department and SCDOI is necessary for the proper administration of the Medicaid Managed Care Program.

19.16 Applicable Laws and Regulations

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

19.16.1 Title XIX of the Social Security Act and 42 Code of Federal Regulations (CFR) Chapter IV, Subchapter C (Medical Assistance Programs);

19.16.2 S.C. Code Ann. § 38-33-10 et. seq. (Supp. 2000, as amended) and 25A S.C. Code Ann. Regs. § 69-22 (Supp. 2000, as amended);

19.16.3 All applicable standards, orders, or regulations issued pursuant to the Clean Air Act of 1970 as amended (42 U.S.C. § 7401, et seq.) and 20 USC § 6082(2) of the Pro-Children Act of 1994, as amended (P.L. 103-227);

19.16.4 Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. § 2000d et seq.) and regulations issued pursuant thereto, (45 CFR Part 80), which provide that the CONTRACTOR must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the Benefits and services provided under this contract;

19.16.5 Title VII of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000e) in regard to employees or Applicants for employment;

19.16.6 Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, which prohibits discrimination on the basis of handicap in programs and activities receiving or benefiting from federal financial assistance, and regulations issued pursuant thereto, 45 CFR Part 84;

19.16.7 The Age Discrimination Act of 1975, as amended, 42 U.S.C § 6101 et seq., which prohibits discrimination on the basis of age in programs or activities receiving or benefiting from federal financial assistance;

19.16.8 The Omnibus Budget Reconciliation Act of 1981, as amended, P.L. 97-35, which prohibits discrimination on the basis of sex and religion in programs and activities receiving or benefiting from federal financial assistance;

19.16.9 The Balanced Budget Act of 1997, as amended, P.L. 105-33, and the Balanced Budget Refinement Act of 1999, as amended, H.R. 3426;

19.16.10 The Americans with Disabilities Act, as amended, 42 U.S.C. § 12101 et seq., and regulations issued pursuant thereto;

19.16.11 Sections 1128 and 1156 of the Social Security Act, as amended, relating to exclusion of CONTRACTORs for fraudulent or abusive activities involving the Medicare and/or Medicaid Program;

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

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

19.16.14 Section 1557 of the Patient Protection and Affordable Care Act.

19.17 Independent Contractor

It is expressly agreed that the CONTRACTOR and any Subcontractors and agents, officers, and employees of the CONTRACTOR or any Subcontractors in the performance of this contract shall act in an independent capacity and not as officers and employees of the Department or the State of South Carolina.

It is further expressly agreed this contract shall not be construed as a partnership or joint venture between the CONTRACTOR or any Subcontractor and the Department and the State of South Carolina.

19.18 Governing Law and Place of Suit

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

19.19 Severability

If any provision of this contract (including items incorporated by reference) is declared or found to be illegal, unenforceable, or void, then both the Department and the CONTRACTOR shall be relieved of all obligations arising under such provision. If the remainder of this contract is capable of performance, it shall not be affected by such declaration or finding and shall be fully performed.

In addition, if the laws or regulations governing this contract should be amended or judicially interpreted as to render the fulfillment of the contract impossible or economically infeasible, both the Department and the CONTRACTOR will be discharged

from further obligations created under the terms of the contract. To this end, the terms and conditions defined in this contract can be declared severable.

19.20 Copyrights

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

19.21 Subsequent Conditions

The CONTRACTOR shall comply with all requirements of this contract and the Department shall have no obligation to enroll any Members into the CONTRACTOR's Health Plan until such time as all of said requirements have been met.

19.22 Incorporation of Schedules/Appendices

All schedules/appendices referred to in this contract are attached hereto, incorporated herein.

19.23 Titles

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

19.24 Political Activity

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

The CONTRACTOR shall also comply with Byrd Anti-Lobbying Amendment and shall file the require certification that each tier will not use federal funds to pay a person or employee or organization for influencing or attempting to influence an officer or employee of any federal agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier shall also disclose any lobbying with nonfederal funds that takes place in connection with obtaining any federal award. Such disclosure is forwarded by tiers to the Recipient (45 CFR part 93). The CONTRACTOR shall ensure that federal funds have not been used for lobbying.

19.25 Force Majeure

The CONTRACTOR shall not be liable for any excess costs if the failure to perform the contract arises out of causes beyond the control and without the fault or negligence of the CONTRACTOR. Such causes may include, but are not restricted to, acts of God or of the public enemy; acts of the government in either its sovereign or contractual capacity; fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually

severe weather; but in every case the failure to perform must be beyond the control and without the fault or negligence of the CONTRACTOR. If the failure to perform is caused by default of a Subcontractor, and if such default arises out of causes beyond the control of both the CONTRACTOR and Subcontractor, and without the fault or negligence of either of them, the CONTRACTOR shall not be liable for any excess costs for failure to perform, unless the supplies or services furnished by the Subcontractors were obtainable from other sources in sufficient time to permit the CONTRACTOR to meet the required delivery schedule.

The Department shall not be liable for any excess cost to the CONTRACTOR for Department's failure to perform the duties required by this contract if such failure arises out of cause beyond the control and without the result of fault or negligence on the part of Department.

19.26 Conflict of Interest

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

19.27 Department Policies and Procedures

The CONTRACTOR shall comply with the applicable Policies and Procedures of the Department, specifically including without limitation the Policies and Procedures for Medicaid Managed Care services, and all Policies and Procedures applicable to each category of Covered Benefits and the services related to the delivery of those Covered Benefits as required by the terms of this contract. In no instance may the CONTRACTOR impose limitations or exclusions with respect to Covered Benefits and related services that are more stringent than those specified in the Department’s applicable Policies and Procedures manuals. The Department must use best efforts to provide prior written notice to CONTRACTOR of applicable material changes to its Policies and Procedures that alter the terms of this contract.

19.28 State and Federal Law

At all times during the term of this contract the CONTRACTOR shall strictly adhere to all applicable federal and state law, regulations and standards, in effect when this contract is signed, or which may come into effect during the term of this contract.

19.29 CONTRACTOR’s Appeal Rights

If any dispute shall arise under the terms of this contract, the sole and exclusive remedy shall be the filing of a Notice of Appeal within thirty (30) Calendar Days of receipt of written notice of Department's action or decision that forms the basis of the Appeal. Administrative Appeals shall be in accordance with 27 S.C. Code Ann. Regs. § 126-150,

et seq. (1976 , as amended), and the Administrative Procedures Act, S.C. Code Ann. § 1-23-310, et seq. (1976, as amended). Judicial review of any final Department administrative decisions shall be in accordance with S.C. Code Ann. § 1-23-380 (1976, as amended).

19.30 Collusion/Anti-Trust

Any activities undertaken by CONTRACTOR that may be construed as collusion or otherwise in violation of any federal or state anti-trust laws may result in termination of this contract and/or referral to the SCAG.

19.31 Inspection of Records

The CONTRACTOR shall make all Program and financial records, (including all books documents and papers utilized in the provision of Medicaid or Medicaid related activities) service delivery sites, physical facilities, and equipment where Medicaid-related activities or work is conducted available at any time to the U.S. DHHS, the Department, GAO, the State, CMS, Office of the Inspector General, Auditor's Office, the Office of the Attorney General, the Comptroller General, or their designee or any Representatives for inspection and audit., U.S. DHHS, the Department, GAO, the State, CMS, Office of the Inspector General, Auditor's Office, the Office of the Attorney General, the Comptroller General, or their designee or any Representatives, have the right of timely and unrestricted access to any books, documents, papers, or other records of CONTRACTOR that are pertinent to the awards, to make audits, examinations, excerpts, transcripts and copies of such documents. This right also includes timely and reasonable access to a Recipient's personnel for the purpose of interview and discussion related to such documents. U.S. DHHS, the Department, GAO, the State, CMS, Office of the Inspector General, Auditor's Office, the Office of the Attorney General, the Comptroller General, or their designee or any Representatives shall have the right to examine and make copies, excerpts or transcripts from all records, contact and conduct private interviews with CONTRACTOR clients and employees, and do on-site reviews of all matters relating to service delivery as specified by this contract. The right to audit under this Section exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. 438.3(h)

19.32 Non-Waiver of Breach

The failure of the Department at any time to require performance by the CONTRACTOR of any provision of this contract, or the continued payment of the CONTRACTOR by the Department, shall in no way affect the right of Department to enforce any provision of this contract; nor shall the waiver of any breach of any provision thereof be taken or held to be a waiver of any succeeding breach of such provision or as a waiver of the provision itself.

19.32.1 No covenant, condition, duty, obligation, or undertaking contained in or made a part of this contract shall be waived except by the written agreement of the parties and approval of CMS, if applicable.

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

19.33 Non-Assignability

No assignment or transfer of this contract or of any rights hereunder by the CONTRACTOR shall be valid without the prior written consent of the Department.

19.34 Legal Services

Legal counsel shall not be retained through use of any funds provided by the Department pursuant to the terms of this contract. Further, with the exception of attorney's fees awarded in accordance with S.C. Code Ann. § 15-77-300, the Department shall under no circumstances become obligated to pay an attorney's fee or the costs of legal action to the CONTRACTOR. This covenant and condition shall apply to any and all suits, legal actions, and judicial Appeals of whatever kind or nature to which the CONTRACTOR is a party.

19.35 Attorney's Fees

In the event that the Department shall bring suit or action to compel performance of or to recover for any breach of any stipulation, covenant, or condition of this contract, the CONTRACTOR shall pay to the Department attorney's fees as determined by the court in addition to the amount of judgment and costs.

19.36 Retention of Records

The CONTRACTOR shall retain records in accordance with 45 CFR § 74.53 and 42 CFR § 438.3 (u) including, but not limited to financial records, supporting documents, statistical records, and all other records pertinent to an award.

19.36.1 Such records shall be retained for a period of three years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following:

19.36.1.1 If any litigation, claim, financial management review, or audit is started before the expiration of the three (3) year period, the records shall be retained until all litigation, claims or audit findings involving the records have been resolved and final action taken.

19.36.1.2 Records for real property and equipment acquired with federal funds shall be retained for three (3) years after final resolution.

19.36.1.3 When records are transferred to or maintained by the U.S. DHHS awarding agency, the three (3) year retention requirement is not applicable to the Recipient.

19.36.1.4 Indirect cost rate proposals, cost allocations plans, etc., as specified in Sec. 74.53(g).

19.36.2 Retain Records in accordance with requirements of 45 CFR Part 74 three (3) years after the final payment is made and all pending matters closed, plus additional time if an audit, litigation, or other legal action involving the records is started before or during the original three (3) year period ends. HIPAA now requires five (5) year record retention.

19.36.3 CONTRACTOR must retain, and require Subcontractors to retain, as applicable, the following information: Enrollee Grievance and Appeal records in 42 CFR §438.416, base data in §438.5(c), MLR reports in §438.8(k), and the data, information, and documentation specified in §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years.

19.37 Open Trade

During the Contract term, including any renewals or extensions, Provider will not engage in the boycott of a person or entity based in or doing business with a jurisdiction with whom South Carolina can enjoy open trade as defined in SC Code Ann. $11-35-5300.

19.38 Counterparts

This Contract may be executed in two or more counterparts, each of which shall be deemed an original, but all of which shall constitute the same instrument. The parties agree that this Contract may be delivered by facsimile or electronic mail with a copied signature having the same force and effect of a wet ink signature.

Section 20. SIGNATURE PAGE

IN WITNESS WHEREOF, the Department and the CONTRACTOR, by their authorized agents, have executed this contract as of the first day of July 2024.

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES "SCDHHS"	"CONTRACTOR"
BY: _____	BY: _____
Eunice Medina, Interim Director	Authorized Signature
	_____
	Print Name
WITNESSES:	WITNESSES:
_____	_____
_____	_____

APPENDIX A. DEFINITIONS AND ABBREVIATIONS

A.1 DEFINITIONS

Abuse – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes Beneficiary practices that result in unnecessary cost to the Medicaid Program.

ACIP– Centers for Disease Control Advisory Committee on Immunization Practices.

Accountant (Independent Certified Public Accountant)- 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.

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

- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner, as defined by the State;
- The failure of the CONTRACTOR to process Grievances, Appeals or expedited Appeals within the timeframes provided in this contract; or
- For a resident of a rural area with only one Medicaid Managed Care Organization (MCO), the denial of a Medicaid member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the CONTRACTOR’s network.

Actuarially Sound Capitation Rates – Actuarially Sound Capitation Rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section. (b) CMS review and approval of Actuarially Sound Capitation Rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:

1) Have been developed in accordance with standards specified in 42 CFR §438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal Financial Participation associated with the covered populations.
2) Be appropriate for the populations to be covered and the services to be furnished under the contract.
3) Be adequate to meet the requirements on MCOs, PIHPs, and PAHPs in 42 CFR §§438.206, 438.207, and 438.208.
4) Be specific to payments for each rate cell under the contract.

5) Payments from any rate cell must not cross-subsidize or be cross-subsidized by payments for any other rate cell.
6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in 42 CFR § 438.3(c)(1)(ii) and (e).
7) Meet any applicable special contract provisions as specified in 42 CFR §438.6.
8) Be provided to CMS in a format and within a timeframe that meets requirements in §438.7.
9) Be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a Medical Loss Ratio standard, as calculated under 42 CFR §438.8, of at least eighty-five (85%) percent for the rate year. The capitation rates may be developed in such a way that the MCO, PIHP, or PAHP would reasonably achieve a Medical Loss Ratio standard greater than eighty-five (85%) percent, as calculated under 42 CFR §438.8, as long as the capitation rates are adequate for reasonable, appropriate, and attainable non-Benefit costs.

Additional Services – A Covered Service provided by the CONTRACTOR which is currently a Non-Covered Service(s) by the SC State Plan for Medical Assistance or is an additional Medicaid Covered Service furnished by the CONTRACTOR to Medicaid Managed Care Program members for which the CONTRACTOR receives no additional capitated payment, and is offered to members in accordance with the standards and other requirements set forth in this contract.

Additional Staffing- Personnel designated by the CONTRACTOR to carry out specified duties within this contract.

Administrative Days – Inpatient hospital Days associated with nursing home level patients who no longer require acute care and are waiting for nursing home placement. Administrative Days must follow an acute inpatient stay.

Administrative Services Contracts or Administrative Services Subcontracts – Are subcontracts or agreement that include but are not limited to:

- Any function related to the management of the Medicaid Managed Care contract with the Department.
- Claims processing including pharmacy Claims.
- Credentialing including those for only primary source verification;
- All Management Service Agreements; and
- All Service Level Agreements with any Division of Subsidiary of a corporate parent owner.

Adverse Benefit Determination – An Adverse Benefit Determination is:

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered Benefit.
2) The reduction, suspension, or termination of a previously authorized service.

3) The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the Claim does not meet the definition of a "Clean Claim" at 42 CFR §447.45(b) of this chapter is not an Adverse Benefit Determination.
4) The failure to provide services in a timely manner, as defined by the State.
5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals.
6) For a resident of a rural area with only one MCO, the denial of an Enrollee's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network.
7) The denial of an Enrollee's request to dispute financial liability, including cost sharing, Copayments, premiums, deductibles, coinsurance, and other Enrollee financial liabilities.

Alternative Payment Model (APM) - A form of payment reform that incorporate quality and total cost of care into the reimbursement for medical services, as opposed to paying Claims with a traditional Medicaid Fee for Service Rate.

Ambulance Services – Ambulance Services, including Ambulance Services dispatched through 911 or its local equivalent, where other means of transportation would endanger the Beneficiary's health (42 CFR §422.113(a)).

American Health Information Management Association (AHIMA) – A professional organization for the field of effective management of health data and Health Record needed to deliver quality healthcare to the public management.

American National Standards Institute (ANSI) – The American National Standards Institute is a private non-profit organization that oversees the development of voluntary consensus standards for products, services, processes, systems, and personnel in the United States.

ANSI ASC X12N 837P – The American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12N 837P (Professional) Version 5010A1 is the current electronic Claim version.

Appeal – A request for review of an Adverse Benefit Determination, as defined in 42 CFR § 438.400.

Applicant – An individual:

- Seeking Medicaid eligibility through written application.
- Whose signed application for Medicaid has been received by the South Carolina Department of Health and Human Services (SC DHHS).

Authorized Representative – An Authorized Representative is an individual granted authority to act on a member's behalf through a written document signed by the Applicant or member, or through another legally binding format subject to applicable authentication and data security standards. Legal documentation of authority to act on behalf of an Applicant or member under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in place of the Applicant's or member's signature.

Baby Net - The Early Intervention System under Part C of the Individuals with Disabilities Education Act (IDEA Part C). For children from birth to age three (3) meeting BabyNet eligibility criteria, the early intervention services offered in the program build upon and provide supports and resources to assist and enhance the learning and development of infants and toddlers with disabilities and special needs.

Behavioral Health – A state of health that encompasses mental, emotional, cognitive, social, behavioral stability including freedom from substance use disorders.

Behavioral Health Provider – Individuals and/or entities that provide Behavioral Health Services.

Behavioral Health Services – The blending of mental health disorders and/or substance use disorders prevention in treatment for the purpose of providing comprehensive services.

Beneficiary – An Applicant approved for and receiving Medicaid Benefits.

Benefit or Benefits – The health care services set forth in this contract, for which the CONTRACTOR has agreed to provide, arrange, and be held fiscally responsible. Also referenced as Core Benefits or Covered Services.

Bonus Pool– A Bonus Pool is a payment that involves undistributed funds accumulated from withhold amounts forfeited by the CONTRACTORS.

Business Days – Monday through Friday from 9 A.M. to 5 P.M., excluding state holidays.

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

Calendar Days – All seven (7) Days of the week (i.e., Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, and Sunday).

Capitation Payment – The monthly payment paid by the Department to a CONTRACTOR for each enrolled Medicaid Managed Care Program member for the provision of benefits during the payment period.

Care Coordination – The manner or practice of planning, directing and coordinating health care needs and services of Medicaid Managed Care Program Members.

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

Care Management – Care Management is a set of activities designed to assist patients and their support systems in managing medical conditions and related psychosocial problems more effectively, with the aims of improving patients' functional health status, enhancing coordination of care, eliminating duplication of services and reducing the need for expensive medical services (NCQA).

Case – An event or situation.

Case Management – A collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes (CMSA, n.d.)

Case Management Society of America (CMSA) – A non-profit association dedicated to the support and development of the profession of Case Management (www.cmsa.org).

Centers for Medicare and Medicaid Services (CMS) – The federal Agency within the U.S. Department of Health and Human Services with responsibility for the Medicare, Medicaid, and the state Children's Health Insurance Program.

Certificate of Coverage – The term describing services and supplies provided to Medicaid Managed Care Program Members, which includes specific information on Benefits, coverage limitations and services not covered. The term "Certificate of Coverage" is interchangeable with the term "Evidence of Coverage".

Cesarean Section – A surgical Procedure used to deliver a baby through incisions in the mother's abdomen and uterus.

Claim – A bill for services, a line item of services, or all services for one Recipient within a bill.

Clean Claim – Claims that can be processed without obtaining additional information from the Provider of the service or from a Third Party.

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

Code of Federal Regulation (CFR) – The Code of Federal Regulations (CFR) is an annual codification of the general and permanent rules published in the Federal Register by the executive departments and agencies of the federal government.

- The CFR is divided into fifty (50) titles representing broad areas subject to Federal regulation.
- Each Title is divided into chapters that are assigned to agencies issuing regulations pertaining to that broad subject area. Each chapter is divided into parts and each part is then divided into sections -- the basic unit of the CFR.
- The purpose of the CFR is to present the official and complete text of agency regulations in one organized publication and to provide a comprehensive and convenient reference for all those who may need to know the text of general and permanent federal regulations.
- The CFR is keyed to and kept up to date by the daily Federal Register. These two publications must be used together to determine the latest version of any given rule. When a Federal agency publishes a regulation in the Federal Register, that regulation usually is an amendment to the existing CFR in the form of a change, an addition, or a removal.

Compliance Committee – For the purposes of this contract, the "Compliance Committee" is an organized group of executive and senior management officials—on the Board of Directors and at

the senior management level—charged with overseeing the CONTRACTOR's compliance program and its compliance with the requirements under the contract.

Compliance Officer – The individual responsible for developing and implementing Policies, procedures, and practices designed to ensure compliance with the requirements of this contract and who reports directly to the Chief Executive Officer (CEO) and the Board of Directors.

Compliance Plan – A collection of written Policies, Procedures, and standards of conduct that articulate the CONTRACTOR's commitment to comply with all applicable requirements and standards under the contract, and all federal and State requirements.

Comprehensive Risk Contract – A risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

- Outpatient hospital services,
- Rural Health Clinic (RHC) services,
- Federally Qualified Health Centers (FQHC) services,
- Other laboratory and X-ray services,
- Nursing facility (NF) services,
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services,
- Family Planning Services,
- Physician services; and
- Home Health services

Continuity of Care – Activities that ensure a continuum approach to treating and providing health care services to Medicaid Managed Care Members consistent with 42 CFR § 438.208, the provisions outlined in this contract and the Managed Care Process and Procedure Manual. This includes, but is not limited to:

- Ensuring appropriate referrals, monitoring, and follow-up to Providers within the network,
- Ensuring appropriate linkage and interaction with Providers outside the network.
- Processes for effective interactions between Medicaid Managed Care Members, in-network and out-of-network Providers and identification and resolution of problems if those interactions are not effective or do not occur.

Contract Dispute – A circumstance whereby the CONTRACTOR and Department are unable to arrive at a mutual interpretation of the requirements, limitations, or compensation for the performance of services under this contract.

CONTRACTOR – The domestic licensed HMO ("MCO") that has executed a formal agreement with the Department to enroll and serve Medicaid Managed Care Program members under the terms of this contract. The term CONTRACTOR shall include all employees, Subcontractors, agents, volunteers, and anyone acting on behalf of, in the interest of, or for a CONTRACTOR.

CONTRACTOR's Controls – For the purposes of this contract, the terms "Contractor's Controls" refers to the Policies and Procedures and performance measures for the following Program integrity and audit functions. Please refer to the Program Integrity Section of this contract for additional details.

Conviction or Convicted – A judgment of Conviction has been entered against an individual or entity by a federal, State, or local court regardless of whether:

- There is a post-trial motion or an Appeal pending, or
- The judgment of Conviction or other record relating to the criminal conduct has been expunged or otherwise removed;
- A federal, State, or local court has made a finding of guilt against an individual or entity;
- A federal, State, or local court has accepted a plea of guilty or nolo contendere by an individual or entity;
- An individual or entity has entered into participation in a first offender, deferred adjudication or other program or arrangement where judgment of Conviction has been withheld.

Copayment – Any cost-sharing payment for which the Medicaid Managed Care Program member is responsible.

Core Benefits – A schedule of health care Benefits provided to Medicaid Managed Care Program members enrolled in the CONTRACTOR's Plan as specified under the terms of this contract.

Corrective Action Plan (CAP) – A narrative of steps taken to identify the most cost-effective actions that can be implemented to correct errors causes. The Department's requirements include, but are not limited to:

- Details of all issues and discrepancies between specific contractual, programmatic and/or security requirements and the CONTRACTOR's Policies, practices, and systems.
- The CAP must also include timelines for corrective actions related to all issues or discrepancies identified and be submitted to the Department for review and approval.

Covered Services – Services included in the South Carolina State Plan for Medical Assistance and covered under the Contractor. Also referred to as Benefits or Covered Benefits.

Credentialing – The CONTRACTOR's determination as to the qualifications and ascribed privileges of a specific Provider to render specific health care services.

Credible Allegation of Fraud – A Credible Allegation of Fraud may be an allegation, which has been verified by the State. Allegations are considered to be credible when they have indications of reliability and the State Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a Case-by-Case basis. Sources include, but are not limited to the following:

- Fraud hotline complaints.

- Claims data mining.
- Patterns identified through Provider audits, civil false Claims Cases, and law enforcement investigations.

Cultural Competency – A set of interpersonal skills that promote the delivery of services in a culturally competent manner to all Medicaid Managed Care Members—including those with limited English proficiency and diverse cultural and ethnic backgrounds—allowing for individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Medicaid Managed Care Members (as required by 42 CFR § 438.206).

Current Procedural Terminology (CPT) – Medical nomenclature used to report medical Procedures and services under public and private health insurance programs (American Medical Association,).

Days – Calendar Days unless otherwise specified.

Department – For the purposes of this contract, the term "Department" is used in reference to the South Carolina Department of Health and Human Services (SCDHHS).

Department Appeal Regulations – Regulations promulgated in accordance with the S.C. Code Ann. §44-6-90 and S.C. Code Ann. §§1-23-310 et seq. (2006, as amended).

Direct Marketing (a.k.a. Cold Call or Cold Calling) – Any unsolicited personal contact with or solicitation of Medicaid Applicants/Eligibles in person, through direct mail advertising or telemarketing by an employee or agent of the MCO for the purpose of influencing an individual to enroll with the Managed Care Plan.

Discovery or Discovered – Identification by the CONTRACTOR, any State Medicaid agency official or designated entities, the federal government, or the Provider of an Overpayment, and the communication of that Overpayment finding or the initiation of a formal Recoupment action without notice as described in 42 CFR § 433.136 When Discovery of Overpayment occurs and its significance.

Disenroll/Disenrollment/Disenrolled– Action taken by Department or its designee to remove a Medicaid Managed Care Program member from the CONTRACTOR's Plan following the receipt and approval of a written request for Disenrollment or a determination made by Department or its designee that the member is no longer eligible for Medicaid or the Medicaid Managed Care Program.

Drug Utilization Review (DUR) – A structured program that monitors and evaluates the use of outpatient prescriptions drugs. The program aims to ensure appropriate, medically necessary, and safe drug therapy and prevents fraud, misuse, and abuse.

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

Dual Eligible (a.k.a. Dual Eligibles) – Individuals that are enrolled in both Medicaid and Medicare Programs and receive Benefits from both Programs.

Durable Medical Equipment- Equipment that provides therapeutic benefits or enables beneficiaries to perform certain tasks that they are unable to undertake otherwise due to certain medical conditions and/or illness.

Early and Periodic Screening Diagnosis and Treatment (EPSDT)- The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.

- Early: Assessing and identifying problems early
- Periodic: Checking children's health at periodic, age-appropriate intervals
- Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
- Diagnostic: Performing diagnostic tests to follow up when a risk is identified, and
- Treatment: Control, correct or reduce health problems found.

States are required to provide comprehensive services and furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, based on federal guidelines.

Earned Premiums – The sum of all monies paid by a policyholder to receive coverage from a health insurer. Relative to the Medical Loss Ratio (MLR) calculation, Earned Premiums may also represent the following characteristics:

- Earned Premiums exclude premium assessments paid to, or subsidies received from, federal and state high-Risk insurance pools created by the Affordable Care Act (2010).
- Earned Premiums exclude adjustments for retroactive rate reductions.
- Earned Premiums are to be reported before insurers deduct premium discounts for Enrollees for health and wellness promotion.
- Earned Premiums should be direct (excluding reinsurance).

Eligible or Eligibles – A person who has been determined eligible to receive services as provided for in the SC State Plan for Medical Assistance under Title XIX.

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

Emergency Services – Covered inpatient and Outpatient Services that are as follows:

- Furnished by a Provider that is qualified to furnish these services under this title; and
- Needed to evaluate or stabilize an Emergency Medical Condition.

Encounter – Any service provided to a Medicaid Managed Care Program member regardless of how the service was reimbursed and regardless of Provider type, practice specialty, or place of services. This would include expanded services/Benefits as defined in this contract.

Enrollee – A Medicaid Beneficiary who is currently enrolled in the State's Medicaid Managed Care Program, specifically a Managed Care Organization (MCO). Other Managed Care Programs may include, but are not limited to: PIHP, PAHP, or PCCM (42 CFR § 438.10 (a)).

Enrollment – The process in which a Medicaid Eligible selects or is assigned to a CONTRACTOR ("MCO") and goes through a managed care educational process as provided by the Department or its agent.

Enrollment (Voluntary) – The process in which an Applicant/Recipient selects a CONTRACTOR and goes through an educational process to become a Medicaid Managed Care Program member of the CONTRACTOR.

Evidence of Coverage – The term which describes services and supplies provided to Medicaid Managed Care Program members, which includes specific information on Benefits, coverage limitations and services not covered. The term "Evidence of Coverage" is interchangeable with the term "Certificate of Coverage."

Excluded Services – Medicaid services not included in the CONTRACTOR's Core Benefits and reimbursed fee-for-service by the State.

Exclusion – Items or services furnished by a specific Provider who has defrauded or Abused the Medicaid Program will not be reimbursed under Medicaid.

External Quality Review (EQR) – The analysis and evaluation by an EQRO of aggregated information on Quality, timeliness, and access to the health care services that an MCO or its CONTRACTORs furnish to Medicaid Recipients.

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

Failure Severity Index Report- A report indicating the CONTRACTOR's overall network adequacy performance as described in the Managed Care Contract and Managed Care Process and Procedure Manual. The report produces an overall weighted score in the areas of Provider specialty, Member Eligibility category and County, Member threshold mileage, and time. The weighted results are then categorized into 4 severity categories of low, mid-low, mid-high, and high for the CONTRACTORs final failure severity ranking.

Family Planning Services – Preconception services that prevent or delay pregnancies and do not include abortion or abortion related services. The services that include examinations and assessments, diagnostic Procedures, health education, and counseling services related to alternative birth control and prevention as prescribed and rendered by Physicians, hospitals, clinics, and pharmacies.

Federal Financial Participation (FFP) – Any funds, either title or grant, from the federal government.

Federal Poverty Level (FPL) – A measure of income level issued annually by the Department of Health and Human Services.

Federally Qualified Health Center (FQHC) – A South Carolina licensed health center certified by the Centers for Medicare and Medicaid Services that receives Public Health Services grants. A FQHC is eligible for state defined cost-based reimbursement from the Medicaid fee-for-service Program. A FQHC provides a wide range of primary care and enhanced services in a medically underserved Area.

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

Final Audit Report – The Final Audit Report (FAR) is provided by an NCQA-licensed audit organization (LO) as part of an NCQA HEDIS Compliance Audit conducted by an NCQA-Certified HEDIS Compliance Auditor (CHCA).

Fraud – In accordance with 42 § CFR 455.2 Definitions, an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes under applicable federal or State law.

Fraud Waste Abuse (FWA) – FWA is the collective acronym for the terms Fraud, Waste and Abuse.

Full-Time Equivalent (FTE) – A Full Time Equivalent position.

Geographic Service Area – Each of the forty-six (46) Counties that comprise the State of South Carolina.

Grievance – Means an expression of dissatisfaction about any matter other than an Action. Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the member's rights.

Grievance System – Refers to the overall system that includes Grievance process, Appeals process, and Medicaid Managed Care Member access to state fair hearing.

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

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

Health Record – A single complete record kept at the site of the member's treatment(s), which documents all of the treatment plans developed, including, but not limited to, outpatient and emergency medical health care services whether provided by the CONTRACTOR, its In Network Provider, or any out of Plan Providers.

1) At a minimum, for hospitals and mental health hospitals, the Health Record must include:
2) Identification of the Beneficiary.
3) Physician name.
4) Date of admission and dates of application for and authorization of Medicaid Benefits if application is made after admission; the plan of care (as required under 456.170 (mental hospitals) or 456.80 (hospitals).
5) Initial and subsequent continued stay review dates (described under 456.233 and 465.234 (for mental hospitals) and 456.128 and 456.133 (for hospitals).
6) Reasons and plan for continued stay if applicable.
7) Other supporting material the committee believes appropriate to include. For non-mental hospitals only:
    a. Date of operating room reservation.
    b. Justification of emergency admission if applicable.

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

High-Risk Member – The High-Risk Members do not meet Low- or Moderate-Risk criteria.

Home and Community Based Services (HCBS) – In-home or community-based support services that assist persons with long term care needs to remain at home as authorized in an approved 1915(c) Waiver or 1915(i) State Plan.

Hospice Services- A service in which the Member is provided palliative care (relief of pain and uncomfortable symptoms) as opposed to curative care for terminally ill individuals.

Hospital Swing Beds – Hospitals participating in both the Medicaid and Medicare Programs, in addition to providing an inpatient hospital level of care, may also provide nursing facility levels of care and be reimbursed as “swing bed” hospitals. A swing bed hospital must be located in a rural area, have fewer than one hundred (100) inpatient beds exclusive of Newborn and intensive care type beds, and be surveyed for compliance by DHEC and certified as meeting federal and State requirements of participation for swing bed hospitals.

Improper Payment – Any payment that is made in error or in an incorrect amount (including Overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements;

- To an ineligible Recipient,

- For ineligible goods or services,
- For goods or services not received (except for such payments where authorized by law),
- That duplicates a payment, or
- That does not account for credit for applicable discounts.

In Lieu of Service (ILOS)- Those services as defined in 42 CFR § 438.3(e)(2).

In Network Provider – A provider that is under contract with a Managed Care Plan to render services to the Plan's covered membership.

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

Incurred But Not Paid Claims (IBNP) – Claims that have been incurred but not paid (IBNP), as determined by the Department's actuary based on Encounter data and made available for review by the CONTRACTOR, shall be included in Benefit Expense.

Incurred Medical Claims – For the purposes of this contract's Medical Loss Ratio (MLR) calculation provisions in *Section 7* of this contract, the definition of Incurred Medical Claims is as follows:

Incurred Claims	=	Direct Claims incurred in MLR reporting year
	+	Unpaid Claim reserves associated with Claims incurred
	+	Change in contract reserves
	+	Claims-related portion of reserves for contingent Benefits and lawsuits
	+	Experience-rated refunds (exclude rebates based on issuers MLR)

Note that prescription drug rebates are to be deducted from incurred Claims

Independent Community Pharmacy – A pharmacy provider that is defined as such through the licensing by the South Carolina Board of Pharmacy.

Indian Health Care Provider (IHCP) - a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

Indian Managed Care Entity (IMCE) - A MCO, PIHP, PAHP, PCCM, or PCCM entity that is controlled (within the meaning of the last sentence of section 1903(m)(1)(C) of the Act) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of one or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

Inmate – One who is housed or confined to a correctional facility (e.g. prison, prison facility, jail etc.) for one or more consecutive calendar months. This does not include individuals on Probation or Parole or who are participating in a community program. Pursuant to 42 CFR § 435.1010, an Inmate of a public institution is defined as "a person living in a public institution", and a public institution is defined as "an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control."

Inquiry – A routine question/s about a Benefit. An inquiry does not automatically invoke a Plan sponsor's Grievance or coverage determination process.

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

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

Intensive Case Management (ICM) – For the purposes of this contract, ICM refers to:

- A more intensive type of intervention in comparison to a standard or traditional Case Management / disease management program where the activities used help ensure the patient can reach his/her care goals.
- A more frequent level of interaction–direct and indirect contact, more time spent–with the Medicaid Managed Care Member. This may include the use of special technology and/or devices, such as telemonitoring devices.

Key Personnel – Individuals employed by the CONTRACTOR who have authority and responsibility for planning, directing and controlling CONTRACTOR activity.

Legal Representative – A "Legal Representative" is a person who has been granted legal authority to look after another's affairs, such as an attorney, executor, administrator, holder of power of attorney, etc.

Limited English Proficiency- means potential members and members who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be Limited English Proficient and may be eligible to receive language assistance for a particular type of service, Benefit, or encounter.

List of Excluded Individuals/Entities (LEIE) – The HHS-OIG maintains the LEIE (List of Excluded Individuals and Entities), a database accessible to the general public that provides information about parties excluded from Medicare, Medicaid, and all other federal health care programs. The LEIE website is located at http://www.oig.hhs.gov/fraud/exclusion.asp and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match by entering the Social Security Number (SSN) or Employer Identification Number (EIN).

The downloadable version of the database may be compared against an existing database maintained by the Provider; however, the downloadable version does not contain SSNs or EINs.

Low-Risk Member – The Low-Risk Members do not meet Moderate- or High-Risk criteria.

LTSS - Long-term services and supports (LTSS) means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider- owned or controlled residential setting, a nursing facility, or other institutional setting.

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

Managed Care Plan – The term "Managed Care Plan" is interchangeable with the terms "CONTRACTOR", "Managed Care Organization" (MCO), "Health Plan", "Plan", or "Health Maintenance Organization" (HMO).

Managed Care Process and Procedure Manual – A supplementary document to the managed care contract. The document lays out specific procedural instructions that need to be followed when providing services to Medicaid Recipients.

Managed Care Report Companion Guide – A supplementary document to the managed care contract. The document lays out specific reporting requirements and templates that need to be followed when providing services to Medicaid Recipients.

Management Service Agreements – A type of Subcontract with an entity in which the CONTRACTOR delegates some or all of the comprehensive management and administrative services necessary to fulfill the CONTRACTOR's obligations to the Department under the terms of this contract.

Marketing – Any communication, from the CONTRACTOR to a Medicaid Recipient who is not enrolled in that entity, that can be reasonably interpreted as intended to influence the Recipient to enroll in that particular MCO Medicaid product, or either to not enroll, or to Disenroll from another MCO Medicaid product. Marketing does not include communication to a Medicaid Beneficiary from the issuer of a qualified Health Plan, as defined in 45 CFR § 155.20, about the qualified health plan.

Marketing Materials – Pursuant to 42 CFR §§ 438.104(a)(i) and 438.104(a)(ii), marketing materials refers to materials that:

- Are produced in any medium, by or on behalf of an MCO (e.g., CONTRACTOR); and

- Can reasonably be interpreted as intended to market the MCO to potential or existing members.

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

Medicaid – The medical assistance Program authorized by Title XIX of the Social Security Act.

Medicaid Integrity Audit Contractor (MIC) – A contractor that performs audit functions under the Medicaid Integrity Program.

Medicaid Integrity Program (MIP) – A Program enacted by the Deficit Reduction Act (DRA) of 2005 which was signed into law in February 2006 and created the Medicaid Integrity Program (MIP) under Section 1936 of the Social Security Act under which CMS hires contractors to review Medicaid Provider activities, audit Claims, identify Overpayments and to support and provide effective assistance to States in their efforts to combat Medicaid Provider fraud and Abuse.

Medicaid Management Information System (MMIS) – The MMIS is an integrated group of Procedures and computer-processing operations (subsystems) developed at the general design level to meet principal objectives. For Title XIX purposes, "systems mechanization" and "mechanized Claims processing and information retrieval systems" is identified in Section 1903(a)(3) of the Act and defined in regulation at 42 CFR § 433.111. The objectives of this system and its enhancements include the Title XIX Program control and administrative costs; service to Recipients, Providers, and inquiries; operations of Claims control and computer capabilities; and management reporting for planning and control.

Medicaid Recipient Fraud Unit (MRFU) – The division of the State Attorney General's Office that is responsible for the investigation and prosecution of Recipient fraud.

Medicaid Recovery Audit Contractor (RAC) – A Medicaid Recovery Audit Contractor who performs audits under the Medicaid Recovery Audit Contractor Program.

Medicaid Recovery Audit Contractor Program – A Medicaid Recovery Audit Contractor Program administered by the State Agency to identify Overpayments and underpayments and recoup Overpayments.

Medical Benefit – Benefit that is covered under a beneficiary's medical insurance plan and billed through a CMS 1500 form.

Medical Loss Ratio (MLR) – The proportion of premium revenues spent on clinical services and Quality improvement, also known as the Medical Loss Ratio (MLR).

Medical Management - Medical Case Management is a collaborative process that facilitates recommended treatment plans to assure the appropriate medical care is provided to Medicaid

members. It refers to the planning and coordination of health care services appropriate to achieve the goal of medical rehabilitation.

Medical Necessity – Services utilized in the State Medicaid Program, including quantitative and non-quantitative treatment limits, to determine the level of need for medical services rendered, as indicated in State statutes and regulations, the State Plan, and other State policy and Procedures.

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

Member Incentive – Incentives to encourage a Medicaid Managed Care Member to change or modify behaviors or meet certain goals.

Member or Medicaid Managed Care Member – An eligible person who is currently enrolled with a Department approved Medicaid Managed Care CONTRACTOR. Throughout this contract, this term is used interchangeably with "Enrollee" and "Beneficiary".

Minimum Performance Standards (MPS) – The CONTRACTOR is expected to meet a minimum level of performance as identified in the Managed Care Process and Procedure Manual— a specific list of Quality metrics (aka the withhold metrics). These minimum levels of performance are referred to as the Minimum Performance Standards (MPS).

Minimum Subcontract Provision (MSP) – Specific contractual requirements the CONTRACTOR must include in Subcontracts.

Moderate-Risk Member – The Moderate-Risk Members do not meet Low- or High-Risk criteria.

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

National Drug Code (NDC) – A unique 10-digit, 3-segment numeric identifier assigned to each medication listed under Section 510 of the US Federal Food, Drug, and Cosmetic Act. The segments identify the labeler or vendor, product (within the scope of the labeler), and trade package (of this product).

National Practitioner Data Bank – A central repository for adverse action and medical malpractice payments. (1-800-767-6732)

National Practitioner Database (NPDB) – The federal information repository dedicated to improving health care quality, promoting patient safety, and preventing fraud and Abuse.

Negative PDL Change- Defined as any of the following changes:

1) Removal of a drug or therapeutic drug class from a single preferred drug list (formulary)
2) Increasing the cost-sharing/co-pay status of a drug on the single preferred drug list (formulary) subsequent to a change in step therapy
3) Adding or making more restrictive utilization management requirements on a drug or therapeutic drug class, including

a. prior authorization requirements
b. quantity limits
c. step therapy requirements

Newborn – A live child born to a member during her membership or otherwise eligible for Voluntary Enrollment under this contract.

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

Non-Covered Services – Services not covered under the SC State Plan for Medical Assistance.

Non-Emergency – An encounter with a health care Provider by a Medicaid Managed Care Program member who has presentation of medical signs and symptoms that do not require immediate medical attention.

Non-Participating Provider – A Provider licensed to practice who has not contracted with or is not employed by the CONTRACTOR to provide health care services.

Outpatient Services – Preventive, diagnostic, therapeutic, rehabilitative, surgical, mental health, facility services for dental, and Emergency Services received by a patient through an outpatient/ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding twenty-four (24) hours.

Overpayment – The amount paid by the CONTRACTOR to a Provider, which is in excess of the amount that is allowable for services furnished under Section 1902 of the Act, or to which the Provider is not entitled and which is required to be refunded under Section 1903 of the Act.

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

Performance Improvement Projects (PIP) – Projects designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction. In accordance with 42 CFR § 438.330 the PIP must involve the following:

- Measurement of performance using objective Quality indicators;
- Implementation of system interventions to achieve improvement in quality;
- Evaluation of the effectiveness of the interventions; and
- Planning and initiation of activities for increasing or sustaining improvement.

Pharmacy Benefit – Outpatient prescriptions that are billed through a pharmacy point of sale system and dispensed by a pharmacist.

Physician – For the purposes of this contract, a “Physician” is any of the following types of professionals that are legally authorized by the state to practice, regardless of whether they are Medicare, Medicaid, or Children's health Insurance Program (CHIP) Providers:

- Doctors of medicine or osteopathy,
- Doctor of Dental Medicine or dental surgery,
- Doctors of podiatric medicine,
- Doctor of Optometry,
- Chiropractors

Plan (a.k.a. Health Plan) – The term "Plan" is interchangeable with the terms "CONTRACTOR," "Managed Care Plan" or "HMO/MCO".

Policies – The general principles by which the Department is guided in its management of the Title XIX Program, as further defined by Department promulgations and state and federal rules and regulations.

Post Stabilization Services – Covered Services, related to an emergency medical condition that are provided after an Enrollee is stabilized to maintain the stabilized condition or are provided to improve or resolve the Enrollee's condition when the CONTRACTOR does not respond to a request for pre-approval within one (1) hour, the CONTRACTOR cannot be contacted, or the CONTRACTOR's Representative and the treating Physician cannot reach an agreement concerning the Member's care and a CONTRACTOR's Provider is not available for consultation.

Premium- A monthly fee that may be paid to Medicare or Medicaid.

Prepaid Ambulatory Health Plan (PAHP) – An entity that:

- Provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid Capitation Payments, or other payment arrangements that do not use State Plan payment rates;
- Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its Enrollees; and
- Does not have a Comprehensive Risk Contract.

Prepaid Inpatient Health Plan (PIHP) – An entity that:

- Provides medical services to Enrollees under contract with the State agency, and on the basis of prepaid Capitation Payments, or other payment arrangements that do not use State Plan payment rates;
- Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its Enrollees; and
- Does not have a Comprehensive Risk Contract.

Prevalent Non-English Language -a non-English language determined to be spoken by a significant number or percentage of potential Enrollees and Enrollees that are limited English proficient.

Primary Care Provider (PCP) – A general practitioner, family Physician, internal medicine Physician, obstetrician/gynecologist, or pediatrician who serves as the entry point into the health

care system for the member. The PCP is responsible for providing primary care, coordinating, and monitoring referrals to specialist care, authorizing hospital services, and maintaining Continuity of Care.

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

Prior Authorization – The act of authorizing specific approved services by the CONTRACTOR before rendered.

Procedure – For the purposes of this contract, Procedure is defined as:

- An act or a manner of proceeding in an action or process;
- Any acceptable and appropriate mode of conducting all or a portion of work—the individual or collective tasks or activities.

Program – The method of provision of Title XIX services to South Carolina Recipients as provided for in the SC State Plan for Medical Assistance and Department regulations.

Programmatic-Level – Pertaining to, consisting of, or resembling a formal program. For the purposes of this contract, Programmatic-Level means:

- A planned, coordinated group of activities, Procedures, etc., often for a specific purpose (e.g., the provision of a series of services, activities, Procedures, tasks necessary to perform and achieve a goal, objective, or requirement).
- A formal operations plan or schedule of activities, Procedures, etc. to be followed to accomplish a specified end or outcome.

Protected Health Information (PHI) – PHI protected health information as defined in 45 CFR §160.103

Provider – In accordance with 42 CFR § 400.203 Definitions specific to Medicaid, any individual or entity furnishing Medicaid services under a Provider agreement with the CONTRACTOR or the Medicaid agency. These may include the following:

- Any individual, group, Physicians (such as but not limited includes Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Outpatient Center (free standing or owned) Clinics and Laboratories) furnishing Medicaid services under an agreement with the Medicaid agency; or
- For the Medicaid Managed Care Program, any individual, group, Physicians (including but not limited to Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Clinics, Outpatient Centers (free standing or owned) and Laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.

Provider Dispute – Refers to a dispute between a Provider and the CONTRACTOR. Disputes may include, but will not be limited to:

- Lost or incomplete Claim(s);
- Request(s) for additional explanation from the CONTRACTOR for service(s) or treatment(s) rendered by a Provider;
- Inappropriate or unapproved referral(s) initiated by Provider(s); or
- Any other reason for billing or non-billing related Disputes.

Provider Dispute System – Refers to a CONTRACTOR's formal internal system for Providers to dispute the CONTRACTOR's Policies, Procedures, or any aspect of the CONTRACTOR's administrative functions.

Provider Incentives or Provider-Designated Incentives – Provider-Designated Incentives are those incentives paid by the CONTRACTOR to qualified Providers for achieving designated goals. Provider-Designated Incentives are paid for the Programs listed in the Managed Care Process and Procedure Manual

Provider Network- The providers with which a Managed Care Organization (MCO) contracts or makes arrangements to furnish covered health care services to Medicaid Members under an MCO coordinated care or network plan.

Quality – As related to external Quality review, the degree to which a CONTRACTOR increases the likelihood of desired health outcomes of its Enrollees through structural and operational characteristics and the provision of health services consistent with current professional knowledge.

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

Quality Assessment and Performance Improvement (QAPI) – Activities aimed at improving in the quality of care provided to enrolled members through established quality management and performance improvement processes

Quality Assurance – The process of assuring that the delivery of health care services provided to members are appropriate, timely, accessible, available, and medically necessary.

Quality Assurance Committee – A variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.) that represent a CONTRACTOR's participating network of Providers—including representation from the CONTRACTOR's management or Board of Directors—from a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.) with an emphasis on primary care, such as obstetrics and pediatrics.

Quality Improvement Expenditures – For the purposes of this contract, these expenditures are defined as expenditures that satisfy the allowable quality initiative criteria and Medical Loss Ratio (MLR) calculation requirements. Both requirements are defined within *Section 7* of this contract.

Recipient – A person who is determined eligible to receive services as provided for in the SC State Plan for Medical Assistance.

Recoupment – The recovery by, or on behalf of, either the State Agency or the CONTRACTOR of any outstanding Medicaid debt.

Redetermination- A person who has been determined eligible to receive services as provided for in the SC State Plan for Medical Assistance under Title XIX after formerly not being eligible under the SC State Plan for Medical Assistance under Title XIX.

Referral Services – Health care services provided to Medicaid Managed Care Program members outside the CONTRACTOR's designated facilities or its Providers when ordered and approved by the CONTRACTOR, including, but not limited to, out-of-Plan services which are covered under the Medicaid Program and reimbursed at the Fee-For-Service Medicaid Rate.

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

Risk – A chance of loss assumed by the CONTRACTOR which arises if the cost of providing Core Benefits and Covered Services to Medicaid Managed Care Program members exceeds the Capitation Payment made by Department to the CONTRACTOR under the terms of this contract.

Rural Health Clinic (RHC) – A South Carolina licensed Rural Health Clinic is certified by the CMS and receiving Public Health Services grants. A RHC eligible for state defined cost-based reimbursement from the Medicaid fee-for-service Program. A RHC provides a wide range of primary care and enhanced services in a medically underserved area.

Screen or Screening – Assessment of a member's physical or mental condition to determine evidence or indications of problems and the need for further evaluation or services.

Serious Mental Illness (SMI) - Individuals who have a serious mental illness as defined in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) under the following categories: schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, major depressive disorders, or a diagnosis of obsessive-compulsive disorder.

OR

Children and adolescents ages 7-18 with any of the above diagnoses or who are considered seriously emotionally disturbed, regardless of current diagnosis.

Along with the above listed criteria, the individual must also experience both of the following:

- At least one acute admission to a psychiatric hospital or two or more emergency department visits within the past 12 months for crisis intervention and treatment of a mental disorder.
- Specific symptoms or disturbances cause the member difficulty in accessing appropriate behavioral health, medical, educational, social, developmental, or other supportive services required for optimal functioning.

Service Area– The geographic area in which the CONTRACTOR is authorized to accept enrollment of eligible Medicaid Managed Care Members into the CONTRACTOR's Health Plan. The Service Area must be approved by SCDOI.

Service Level Agreement (SLA) – A type of Subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the CONTRACTOR specifically related to fulfilling the CONTRACTOR's obligations to the Department under the terms of this contract.

Significant Business Transactions – Any business transaction or series of transactions during any of the fiscal year that exceed the $25,000 or five (5%) percent of the CONTRACTOR's total operating expenses.

Significant Change - A major decline or improvement in a Member's status that meets all the following requirements:

- The change would not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, and the decline is not considered "self-limiting";
- The change impacts more than one area of the resident's health status;
- The change requires interdisciplinary review and/or revision of the care plan.

South Carolina Department of Health and Human Services (SCDHHS) – SCDHHS and Department are interchangeable terms and definitions they are one in the same and one maybe be used to define the other in this document. as well as in the MCO Contract.

Social Security Administration (SSA) – An independent agency of the United States federal government that administers Social Security, a social insurance program consisting of retirement, disability, and survivors' Benefits.

Social Security Administration's Death Master File (SSDMF) – The SSA Limited Access Death Master File is used by leading government, financial, investigative, credit reporting organizations, medical research, and other industries to:

1) Verify death as well as to prevent fraud, and
2) Comply with the USA Patriot Act. Access to the Death Master File is restricted and requires all users to complete the following certification form.

All questions and concerns regarding the certification form, should be directed to NTIS at subscriptions@ntis.gov or 1-800-363-2068. The Limited Access Death Master File (DMF) from the Social Security Administration (SSA) contains over 86 million records of deaths that have been reported to SSA. This file includes the following information on each decedent, if the data are available to the SSA:

- Social security number,
- Name,
- Date of birth, and

- Date of death.

The SSA does not have a death record for all persons; therefore, SSA does not guarantee the veracity of the file. Thus, the absence of a particular person is not proof this person is alive.

Social Services – Medical assistance, rehabilitation, and other services defined by Title XIX, and Department regulations.

South Carolina Healthy Connections Choices- South Carolina Medicaid's contracted Enrollment broker for Managed Care Members.

South Carolina Healthy Connections Medicaid- The Title XIX program administered by the Department, also known as South Carolina Medicaid.

South Carolina Medicaid Network Provider – A Provider of healthcare services or products which includes but is not limited to an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, group or association approved and enrolled by the Department, licensed and/or credentialed which accepts as payment in full for providing benefits to Medicaid Managed Care Members amounts pursuant to the CONTRACTOR's reimbursement provisions, business requirements and schedules.

South Carolina State Plan for Medical Assistance (State Plan) – A plan, approved by the Secretary of HHS, which complies with 42 U.S.C.A. § 1396a, and provides for the methodology of furnishing services to Recipients pursuant to Title XIX.

Specialist- A healthcare professional who treats only certain parts of the body, certain health conditions, or certain age groups.

Special Populations – Individuals that may require unique considerations and/or tailored health care services that should be incorporated into a Care Management Plan that guarantees that the most appropriate level of care is provided for these individuals.

Subcontract – A written agreement between the CONTRACTOR and a Third Party to perform a part of the CONTRACTOR's obligations as specified under the terms of this contract.

Subcontractor – Any organization or person who provides any business functions or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to Department under the terms of this contract.

Subrogation – The right of the Department to stand in the place of the CONTRACTOR or client in the collection of Third-Party Resources.

Supplemental Security Income (SSI) – Benefits paid to disabled adults and children who have limited income and resources.

Suspension of Payment for Credible Allegation – In accordance with42 CFR § 455.23 Suspension of payment in cases of fraud, means that all Medicaid payments to a Provider are suspended after the agency determines there is a Credible Allegation of Fraud for which an

investigation is pending under the Medicaid Program against an individual or entity unless the agency has good cause to not suspend payments or to suspend payment only in part.

Targeted Case Management (TCM) – Services that assist individuals in gaining access to needed medical, social, educational, and other services as authorized under the State Plan. Services include a systematic referral process to Providers.

Third Parties – Third Parties are other individuals or entities, whether or not they operate in the United States.

Third Party Liability (TPL) – Collection from other parties who may be liable for all or part of the cost of items or health care services provided to a Medicaid Managed Care Program member.

Third Party Resources – Any entity or funding source other than the Medicaid Managed Care Program member or his/her responsible party, which is or may be liable to pay for all or part of the cost of medical care provided to a Medicaid Managed Care Program member.

Title XIX – Title 42, United States Code, Chapter 7, subchapter XIX, as amended. (42 U.S.C.A. § 1396 et seq.)

Transition Plan – A formal document that provides a detailed description of the process for transitioning Medicaid Managed Care Members between various healthcare settings or from out-of-network Providers to the CONTRACTOR's Provider network to ensure optimal Continuity of Care. Functions include coordination of hospital/institutional discharge planning and post discharge care, assisting to schedule any follow-up appointments, collaborating with the hospital/institution discharge planner/coordinator to implement the discharge plan in the enrollees home, facilitating communication with community service providers and coordination of care after emergency department visits.

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

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

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

Vulnerable Adults and Medicaid Provider Fraud Control Unit (VAMPF) – The division of the State Attorney General’s Office that is responsible for the investigation and prosecution of Provider Fraud.

Waste – The unintentional misuse of Medicaid funds through inadvertent error that most frequently occurs as incorrect coding and billing.

Withhold – A percentage of payments or set dollar amount that an organization deducts for a Physician's service fee, capitation, or salary payment, and may or may not be returned to the Physician, depending on the specific predetermined factors.

A.2 ABBREVIATIONS

AAP	American Academy of Pediatrics
AAPC	American Academy of Professional Coders
ACA	Patient Protection and Affordable Care Act
ACD	Automated Call Distribution System
ACIP	Advisory Committee on Immunization Practices
ACR	Average Commercial Rate
ADA	Americans with Disabilities Act
ADL	Activities of Daily Living
AHIMA	American Health Information Management Association
AHRQ	Agency for Healthcare Research and Quality
Ann.	Annotated
ANSI	American National Standards Institute
APM	Alternative Payment Model
ASAM	American Society for Addiction Medicine
ASC	Accredited Standards Committee
BEOMB	Beneficiary Explanation of Benefits
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Corrective Action Plan
CCN	Claim Control Number
CCS-P®	Certified Coding Specialist—Physician-Based
CDC	Centers for Disease Control
CEO	Chief Executive Officer
CER	Comparative Effectiveness Review
CFO	Chief Financial Officer
CFR	Code of Federal Regulation
CHCA	Certified in HEDIS Compliance Auditor

CHCQM	Certified in Health Care Quality and Management
CHIP	Children's Health Insurance Program
CLIA	Clinical Laboratory Improvement Amendments
CLTC	Community Long-Term Care
CMS	Centers for Medicare and Medicaid Services
CMSA	Case Management Society of America
COO	Chief Operating Officer
CPHQ	Certified Professional in Health Care Quality
CPT	Current Procedural Terminology, fourth edition, revised 2007
CY	Calendar Year
DAODAS	Department of Alcohol and Other Drug Abuse Services
DHHS	United States Department of Health and Human Services
DME	Durable Medical Equipment
DSH	Disproportionate Share Hospitals
DRA	Deficit Reduction Act
DRG	Diagnosis-Related Group
DOT	Directly Observed Therapy
DUR	Drug Utilization Review
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
EPHI	Electronic Protected Health Information
EQI	Encounter Quality Initiative
EQR	External Quality Review
EQRO	External Quality Review Organization
ESRD	End-Stage Renal Disease
ET	Eastern Time
Et Seq	Meaning "and the following"
FAR	Final Audit Report
FDA	Food and Drug Administration

FFP	Federal Financial Participation
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentages
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
FWA	Fraud, Waste and Abuse
FY	Fiscal Year
GAO	U.S. General Accounting Office or Accountability Office
GME	Graduate Medical Education
H.R	House of Representatives
HAC	Hospital Acquired Conditions
HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HHS	Health and Human Services
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act of 1996
HIT	Health Insurance Tax (a.k.a. Health Insurance Fee)
HITECH	Health Information Technology for Economic and Clinical Health Act
HMO	Health Maintenance Organization
ICM	Intensive Case Management
ICF/IID	Intermediate Care Facility for Individuals with Intellectual Disabilities
ID	Identification Number
IDSS	Interactive Data Submission System
IHCP	Indian Health Care Provider
IMCE	Indian Managed Care Entity
IMD	Institute for Mental Disease

IP	In-Patient (Hospital)
IVR	Interactive Voice Response
LEA	Local Education Authorities
LEIE	List of Excluded Individuals/Entities
LIP	Licensed Independent Practitioner
LIS	Low-Income Subsidy
LISW	Licensed Independent Social Worker
LPHA	Licensed Practitioner of the Healing Arts
LTC	Long-Term Care
LTSS	Long-Term Services and Supports
NAIC	National Association of Insurance Commissioners
MA	Medicare Advantage Plan
MCAC	Medical Care Advisory Committee
MCO	Managed Care Organization
MCE	Managed Care Entity
MHPAEA	Mental Health Parity and Addiction Equity Act of 2008
MI	Mental Illness
MIC	Medicaid Integrity Audit Contractor
MIP	Medicaid Integrity Program
MLR	Medical Loss Ratio
MLTSS	Managed Long-Term Services and Supports
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MMIS	Medicaid Management Information System
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MPS	Minimum Performance Standards
MRFU	Medicaid Recipient Fraud Unit
MSP	Minimum Subcontract Provision

NAHQ	National Association for Healthcare Quality
NCCI	National Correct Coding Initiative
NCPDP	National Council for Prescription Drug Program
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
No	Number
NP	Nurse Practitioner
NPI	National Provider Identification Number
NPDB	National Practitioner Database
OB/GYN	Obstetrics / Gynecology
OIG	Office of Inspector General
OP	Outpatient (Hospital)
OPAC	Outpatient Pediatric AIDS Clinic
P.L.	Public Law
P&T	Pharmacy & Therapeutics Committee
PAHP	Prepaid Ambulatory Health Plan
PASARR	Preadmission Screening and Resident Review
PBM	Pharmacy Benefits Manager
PCAT	Payment Category
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PDL	Preferred Drug List
PDP	Prescription Drug Plan
PHI	Protected Health Information
PI	Program Integrity
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMPM	Per Member Per Month

PPC	Provider Preventable Conditions
PPS	Prospective Payment System
PRTF	Psychiatric Residential Treatment Facilities Demonstration
QA	Quality Assessment
QAP	Quality Assessment Program
QAPI	Quality Assessment and Performance Improvement
QI	Qualifying Improvement
QIO	Quality Improvement Organization
RAC	Medicaid Recovery Audit Contractor
Regs	Regulations
RHC	Rural Health Center
RN	Registered Nurse
Rx	Prescription Drugs
SA	Service Authorization
SAM	System for Award Management
SC or S.C	South Carolina
SCAG	SC Office of the Attorney General
SCDHEC	SC Department of Health and Environmental Control
SCDHHS	SC Department of Health and Human Services
SCDOI	SC Department of Insurance
SCDOR	South Carolina Department of Revenue
SCHCC	South Carolina Healthy Connections Choices
SFY	State Fiscal Year
SIU	Special Investigation Unit
SLA	Service Level Agreement
SMOG	Simple Measure of Gobbledygook
SPA	State Plan Amendment
SPMI	Serious and Persistent Mental Illness

SPLIP	Statewide Pharmacy Lock-In Program
SSDMF	Social Security Administration Death Master File
SSA	Social Security Administration
SSI	Supplemental Security Income
Stat.	Statute
STD	Sexually Transmitted Disease
STP	Supplemental Teaching Payment
Supp.	Supplement
SUD	Substance Use Disorder
SUR	Surveillance Utilization Review
TANF	Temporary Assistance for Needy Families
TB	Tuberculosis
TCM	Targeted Case Management
TCP/IP	Transmission Control Protocol/Internet Protocol
TMSIS	Transformed Medicaid Statistical Information System
TPL	Third Party Liability
TTY/TTD	Teletypewriter Device for the Deaf
UB-04	Provider Claim Form (aka CMS-1450 Form)
UM	Utilization Management
U.S	United States
U.S.C	United States Code
U.S.C.A	United States Code Annotated
VAMPF	Vulnerable Adults and Medicaid Provider Fraud Unit
VPN	Virtual Private Network
X-Ray	Energetic High-Frequency Electromagnetic Radiation

APPENDIX B. CAPITATION AND REIMBURSEMENT METHODOLOGY

APPENDIX C. HIPAA BUSINESS ASSOCIATE

C.1 PURPOSE

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

C.2 DEFINITIONS

Terms used in this Section, but not otherwise defined, shall have the same meaning as set forth for those terms in HIPAA. A change to HIPAA which modifies any defined HIPAA term, or which alters the regulatory citation for the definition shall be deemed incorporated into this Appendix).

C.2.1 Business Associate – "Business Associate" shall mean the CONTRACTOR. Where the term “business associate” appears without an initial capital letter, it shall have the same meaning as the term “business associate” in 45 CFR § 160.103.

C.2.2 Covered Entity – "Covered Entity" shall mean SCDHHS.

C.2.3 Data Aggregation – “Data Aggregation” shall have the meaning given to the term in 45 CFR § 164.501.

C.2.4 Designated Record Set – “Designated Record Set” shall have the meaning given the term in 45 CFR § 164.501.

C.2.5 Electronic Protected Health Information (EPHI) –“Electronic Protected Health Information” or “EPHI” shall have the meaning given the term in 45 CFR § 160.103, and shall include, without limitation, any EPHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity.

C.2.6 HIPAA – “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, Public Law 104-91, as amended, and related HIPAA regulations (45 CFR Parts 160-164).

C.2.7 HITECH – “HITECH” means the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005.

C.2.8 Individual – "Individual" shall have the same meaning as the term "individual" in 45 CFR § 160.103 and shall include a person who qualifies as a personal Representative in accordance with 45 CFR § 164.502(g).

C.2.9 Privacy Rule – "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information, and Security Standards for the

Protection of Electronic Protected Health Information (the “Security Rule”) that are codified at 45 CFR Parts 160 and Part 164, Subparts A, C, and E and any other applicable provision of HIPAA, and any amendments thereto, including HITECH.

C.2.10 Protected Health Information (PHI) – "Protected Health Information" or “PHI” shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, and shall include, without limitation, any PHI provided by Covered Entity or created or received by Business Associate on behalf of Covered Entity. Unless otherwise stated in this Agreement, any provision, restriction, or obligation in this Appendix related to the use of PHI shall apply equally to EPHI.

C.2.11 Required By Law – "Required By Law" shall have the same meaning as the term "required by law" in 45 CFR § 164.103, and any additional requirements created under HITECH.

C.2.12 Secretary – "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.

C.2.13 Security Incident – “Security Incident” means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system as provided in 45 CFR § 164.304.

C.2.14 Unsecured PHI – “Unsecured PHI” shall have the same definition that the Secretary gives the term in guidance issued pursuant to § 13402 of HITECH.

C.3 BUSINESS ASSOCIATE AGREES TO:

C.3.1 Not use or disclose PHI or EPHI other than as permitted or required by the Contract or as Required by Law.

C.3.2 Develop, implement, maintain, and use appropriate safeguards to prevent any use or disclosure of the PHI or EPHI other than as provided by this Appendix, and to implement administrative, physical, and technical safeguards as required by Sections 164.308, 164.310, 164.312 and 164.316 of title 45, Code of Federal Regulations and HITECH in order to protect the confidentiality, integrity, and availability of EPHI or PHI that Business Associate creates, receives, maintains, or transmits, to the same extent as if Business Associate were a Covered Entity. See HITECH § 13401.

C.3.3 The additional requirements of Title XIII of HITECH that relate to privacy and security and that are made applicable with respect to covered entities shall also be applicable to Business Associate and shall be and by this reference hereby incorporated into this Appendix.

C.3.4 Adopt the technology and methodology standards provided in any guidance issued by the Secretary pursuant to HITECH § 13401-13402.

C.3.5 Mitigate to the extent practicable, any harmful effect known to Business Associate if Business Associate uses/discloses PHI in violation of the Contract or this Appendix and to notify Covered Entity of any breach of unsecured PHI, as required under HITECH § 13402.

C.3.6 Immediately report to Covered Entity any breaches in privacy or security that compromise PHI or EPHI. Security and/or privacy breaches should be reported by email to privacyoffice@scdhhs.gov. Additional contact information for the Privacy Official is as follows:

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

The Report shall include the identification of each individual whose Unsecured PHI has been, or is reasonably believed by the Business Associate to have been, accessed, acquired, or disclosed during the breach. If the breach involves the Unsecured PHI of more than 500 residents of South Carolina or residents of a certain region, or is reasonably believed to have been accessed, acquired, or disclosed during such incident, the Covered Entity will also notify the prominent media outlets. The media outlets must serve the geographic area affected.

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

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

C.3.7 Ensure that any agent/Subcontractor to whom it provides PHI agrees to the same restrictions/conditions that apply to the Business Associate in this Appendix. Business Associate must obtain, prior to making any permitted disclosure to any agent/Subcontractor, reasonable assurances from such Third Party that such PHI will be held secure and confidential as provided pursuant to this Appendix and only disclosed as required by law or for the purposes for which it was disclosed to such Third Party, and that any breaches of confidentiality of the PHI which become known to such Third Party will be immediately reported to Business Associate. As part of obtaining this reasonable assurance, Business Associate agrees to enter into a Business Associate Agreement with each of its Subcontractors pursuant to 45 CFR § 164.308(b)(1) and HITECH § 13401.

C.3.8 If the Business Associate has PHI in a Designated Record, provide access at the request of Covered Entity, and in the time and manner designated by Covered Entity, to PHI in a Designated Record Set, to Covered Entity or, as directed by

Covered Entity, to an Individual in order to meet the requirements under 45 CFR § 164.524.

C.3.9 If the Business Associate has PHI in a Designated Record Set, make any amendment(s) to PHI in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 CFR § 164.526 at the request of Covered Entity or an Individual, and in the time and manner designated by Covered Entity.

C.3.10 Make internal practices, books, and records, including Policies and Procedures and PHI, relating to the use and disclosure of PHI received from, or created or received by Business Associate on behalf of, Covered Entity available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's compliance with the Privacy Rule.

C.3.11 Document such disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

C.3.12 Provide to Covered Entity or an Individual, in a time and manner designated by Covered Entity, information collected in accordance with *Section C.8* of this Appendix, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528.

C.3.13 Encrypt all PHI stored on portable devices. Portable devices include all transportable devices that perform computing or data storage, manipulation or transmission including, but not limited to, diskettes, CDs, DVDs, USB flash drives, laptops, PDAs, Blackberrys, cell phones, portable audio/video devices (such as Ipods, and MP3 and MP4 players), and personal organizers. Portable devices that perform computing, data manipulation or data transmission are called intelligent portable devices.

C.3.14 Business Associate understands and agrees that, should SCDHHS be found in violation of the HIPAA Privacy Rule due to Business Associate's material breach of this Section, Business Associate shall be liable to SCDHHS for any damages, penalties and/or fines assessed against SCDHHS as a result of Business Associate's material breach. SCDHHS is authorized to recoup any and all such damages, penalties and/or fines assessed against SCDHHS by means of withholding and/or offsetting such damages, penalties, and/or fines against any and all sums of money for which SCDHHS may be obligated to the Business Associate under any previous contract and/or this or future contracts. In the event there is no previous contractual relationship between the Business Associate and SCDHHS, the amount to cover such damages, penalties and/or fines shall be due from Business Associate immediately upon notice.

C.4 PERMIT USES AND DISCLOSURES BY BUSINESS ASSOCIATE

C.4.1 Except as limited in this Appendix, Business Associate may use PHI to perform functions, activities, or services for, or on behalf of, Covered Entity as specified in the Contract noted in A. provided that such use would not violate the Privacy Rule if done by Covered Entity or the Covered Entity's minimum necessary Policies and Procedures. Unless otherwise permitted in this Appendix, in the Contract noted in A. above or as required by Law, Business Associate may not disclose or re-disclose PHI except to Covered Entity.

C.4.2 Except as limited in this Appendix, Business Associate may use or disclose PHI for the proper internal management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, as needed for Business Associate to provide services to Covered Entity under the above noted Contract.

C.4.3 Except as limited in this Appendix, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 45 CFR § 164.504(e)(2)(i)(B).

C.4.4 Business Associate may use PHI to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR § 164.502(j)(1).

C.5 COVERED ENTITY SHALL:

C.5.1 Notify Business Associate of any limitation(s) in its notice of privacy practices of Covered Entity in accordance with 45 CFR § 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

C.5.2 Notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

C.5.3 Notify Business Associate of any restriction to the use/disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect Business Associate's use/disclosure of PHI.

C.5.4 Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

C.6 TERM AND TERMINATION

C.6.1 The terms of this Appendix shall be effective immediately upon award of the Contract noted in *C.1.* and shall terminate when all of the PHI provided by Covered Entity to Business Associate, or created or received by Business Associate on behalf of Covered Entity, is returned to Covered Entity, or, if it is infeasible to return PHI, protections are extended to such PHI in accordance with the termination provisions in this Section.

C.6.2 Upon Covered Entity's knowledge of a material breach by Business Associate, Covered Entity shall:

C.6.2.1 Provide an opportunity for Business Associate to cure the breach or end the violation and terminate the Contract if Business Associate does not cure the breach or end the violation within the time specified by Covered Entity; OR

C.6.2.2 Immediately terminate the Contract if Business Associate has breached a material term of this Appendix and cure is not possible; OR

C.6.2.3 If neither termination nor cure is feasible, Covered Entity shall report the violation to the Secretary.

C.6.3 Effect of Termination.

C.6.3.1 Except as provided in paragraph (2) below, upon termination of the Contract, for any reason, Business Associate shall return all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity. This provision applies to PHI in the possession of Subcontractors or agents of Business Associate. Business Associate shall retain no copies of the PHI.

C.6.3.2 In the event that Business Associate determines that returning the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return infeasible. Upon mutual agreement of the parties that return of PHI is infeasible, Business Associate shall extend the protections of this Appendix to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return infeasible, for so long as Business Associate maintains such PHI.

C.7 SECURITY COMPLIANCE

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

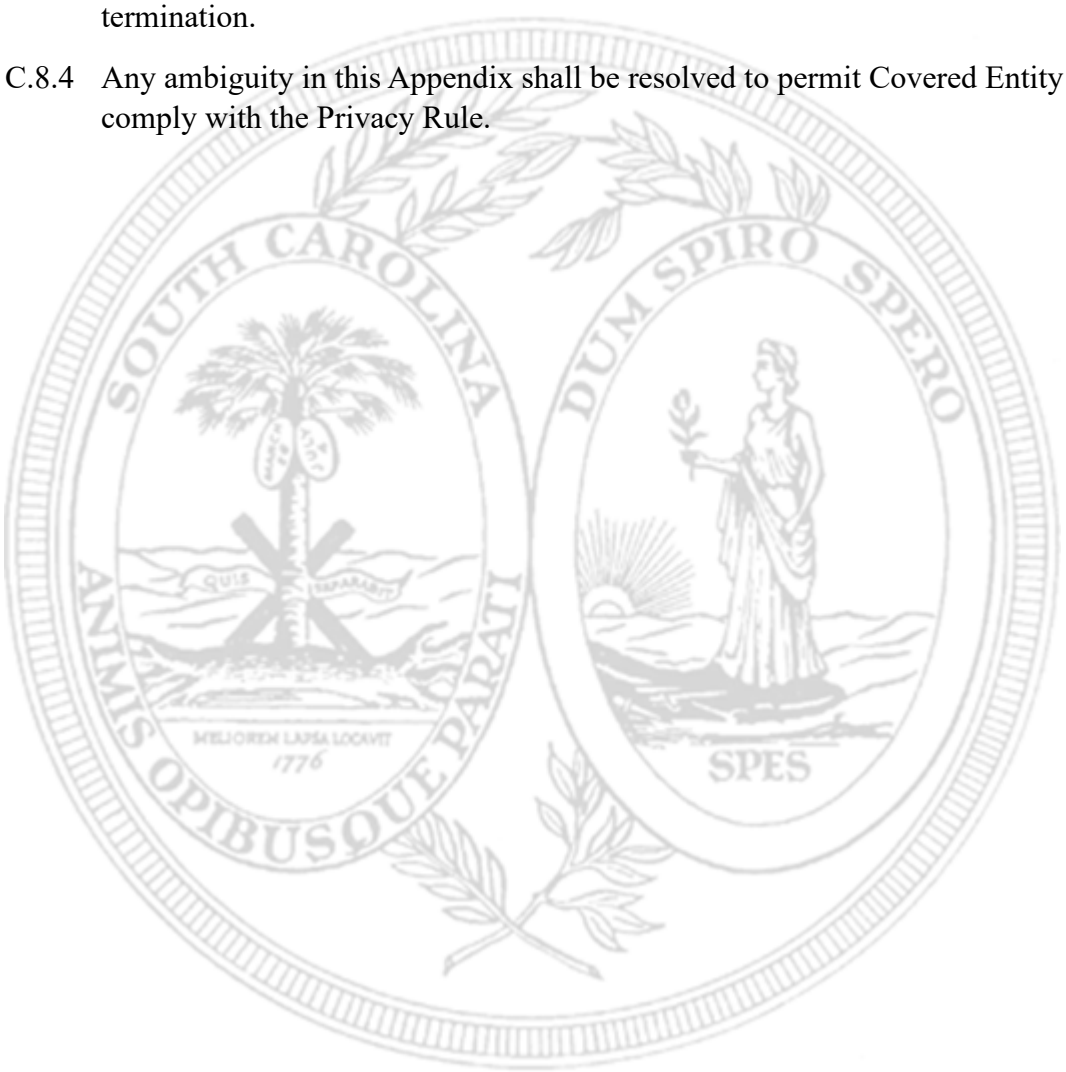
C.8 MISCELLANEOUS

C.8.1 A reference in this Appendix to a section in the Privacy Rule means the section as in effect or as amended.

C.8.2 The Parties agree to amend this Appendix as necessary to comply with HIPAA and other applicable law.

C.8.3 Any provision related to the use, disclosure, access, or protection of EPHI or PHI or that by its terms should survive termination of this Agreement shall survive termination.

C.8.4 Any ambiguity in this Appendix shall be resolved to permit Covered Entity to comply with the Privacy Rule.



Appendix D. SUBCONTRACTOR BOILERPLATE

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES REQUIRED SUBCONTRACT BOILERPLATE

If any of the Contractor's activities or obligations under its contract with SCDHHS (MCO Contract) are delegated to a Subcontractor:

(i) The delegated activities or obligations, and related reporting responsibilities, must be specified in the Subcontract.

(ii) The Subcontractor must agree to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's obligations in the MCO Contract with SCDHHS.

(iii) The Subcontract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where SCDHHS or the Contractor determines that the Subcontractor has not performed satisfactorily.

Further, the following language is required by SCDHHS as a condition of participation in the Medicaid program as the Subcontractor of the Contractor:

D.1 To the extent that any other provision of this Subcontract conflicts with any provision or requirement set forth within this Section, SCDHHS's required language shall be controlling. Any other provision in this Subcontract notwithstanding, in the event that SCDHHS shall modify, amend, or otherwise change the required Subcontract language, as set forth in the Managed Care Contract between SCDHHS and the Contractor (MCO Contract), Subcontractor understands and agrees that the SCDHHS-required Subcontract boilerplate shall be amended to conform to SCDHHS's requirements and standards, without the need for a signed, written amendment.

D.1.1 DEFINITIONS

SCDHHS requires that the defined terms provided below shall be used consistent with the definitions provided here throughout all documents related to the Medicaid Managed Care Program.

Action – As related to Grievance, either (1) the denial or limited authorization of a requested service, including the type or level of service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by the Department; (5) the failure of the CONTRACTOR to act within the timeframes provided in *section 9.7.1* of the MCO Contract; or (6) for a resident of a rural area with only one CONTRACTOR, the denial of a Medicaid Managed Care Member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the CONTRACTOR's network.

Additional Services – A service(s) provided by the CONTRACTOR that is a non-covered service(s) by the South Carolina State Plan for Medical Assistance and is offered to Medicaid Managed Care Members in accordance with the standards and other requirements set forth in the Department's Medicaid Managed Care Contract that are outlined in another section of this Contract.

Administrative Services Contracts or Administrative Services Subcontracts – Are Subcontracts or agreement that include but are not limited to: 1) any function related to the management of the Medicaid Managed Care Contract with the Department; 2) Claims processing including pharmacy Claims; 3) credentialing including those for only primary source verification; 4) all Management Service Agreements; and 5) all Service Level Agreements (SLAs) with any Division of Subsidiary of a corporate parent owner.

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

Continuity of Care – The continuous treatment for a condition (such as pregnancy) or duration of illness from the time of first contact with a healthcare Provider through the point of release or long-term maintenance.

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

Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a Provider that is qualified to furnish these services under Title 42 of the Code of Federal Regulations; and (2) needed to evaluate or stabilize an Emergency Medical Condition.

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

Grievance – An expression of dissatisfaction about any matter other than an Action. The term is also used to refer to the overall system that includes Grievances and appeals handled at the CONTRACTOR level. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Medicaid Managed Care Member's rights.)

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a Comprehensive Risk Contract that is (1) a Federally qualified HMO that meets the

advance directive requirements of subpart I of 42 CFR Part 489; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) makes the services it provides to its Medicaid Managed Care Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area serviced by the entity; and (b) meets the solvency standards of 42 CFR § 438.116. This includes any of the entity's employees, affiliated Providers, agents, or CONTRACTORs.

Management Service Agreements – A type of Subcontract with an entity in which the CONTRACTOR delegates some or all of the comprehensive management and administrative services necessary for the operation of the CONTRACTOR.

Medically Necessary Service – Those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid Managed Care Member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of the Medicaid Managed Care Member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

Medicaid Managed Care Member – An eligible person(s) who is enrolled with a Department approved Medicaid Managed Care Organization (MCO, a.k.a. CONTRACTOR). For purpose of this Subcontract, Medicaid Managed Care Member shall include the patient, parent(s), guardian, spouse, or any other person legally responsible for the Medicaid Managed Care Member being served.

Minimum Subcontract Provision (MSP) – Minimum Service Provisions are detailed in subsection D.2 below.

Primary Care Provider (PCP) – The Provider, serving as the entry point into the health care system, for the Medicaid Managed Care Member responsible for providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining Continuity of Care.

Provider – In accordance with 42 CFR § 400.203 Definitions specific to Medicaid, any individual or entity furnishing Medicaid services under a Provider agreement with the CONTRACTOR or the Medicaid agency. These may include the following:

- Any individual, group, Physicians (such as but not limited includes Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Outpatient Center (free standing or owned) Clinics and Laboratories) furnishing Medicaid services under an agreement with the Medicaid agency; or
- For the Medicaid Managed Care Program, any individual, group, Physicians (including, but not limited to, Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Clinics, Outpatient

Centers (free standing or owned) and Laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.

Rural Health Clinic (RHC) – A South Carolina licensed Rural Health Clinic is certified by the Centers for Medicare and Medicaid Services and receiving Public Health Services grants. An RHC is eligible for state defined cost-based reimbursement from the Medicaid fee-for-service program. An RHC provides a wide range of primary care and enhanced services in a medically underserved area.

Service Level Agreement (SLA) – A type of Subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative functions or services for the CONTRACTOR specifically related to fulfilling the CONTRACTOR's obligations to the Department under the terms of this Contract.

South Carolina Medicaid Network Provider – A Provider of healthcare services or products which includes but is not limited to an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, group or association approved and enrolled by the South Carolina Department of Health and Human Services, licensed and/or credentialed which accepts as payment in full for providing benefits to Medicaid Managed Care Members amounts pursuant to the CONTRACTOR's reimbursement provisions, business requirements and schedules.

Subcontract – A written agreement between the CONTRACTOR and a third party to perform a part of the CONTRACTOR's obligations as specified under the terms of the MCO Contract.

Subcontractor – Any organization or person who provides any functions or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to Department under the terms of the MCO Contract.

D.1.2 ADMINISTRATIVE REQUIREMENTS

D.1.2.1 SCDHHS retains the right to review any and all Subcontracts entered into for the provision of any services Contractor is obligated to perform under the MCO Contract.

D.1.2.2 The Contractor and the Subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and no dispute shall disrupt or interfere with the Continuity of Care of a Medicaid Member.

D.1.2.3 The Subcontractor represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Subcontractor further covenants that, in

the performance of this Subcontract, no person having any such known interests shall be employed.

D.1.2.4 The Subcontractor recognizes that in the event of termination of the MCO Contract, the Contractor is required to make available to SCDHHS, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the Contractor's and Subcontractor's activities undertaken pursuant to this Subcontract. The Subcontractor agrees to furnish any records to the Contractor that the Contractor would need in order to comply with this provision. The provision of such records shall be at no expense to SCDHHS.

D.1.2.5 SCDHHS must be notified of the intent to terminate this Subcontract at least one hundred twenty (120) days prior to the effective date of termination. The date of termination will be at midnight on the last day of the month of termination.

D.1.2.6 If the termination of this Subcontract is as a result of a condition or situation that would have an adverse impact on the health and safety of Medicaid Members, the termination shall be effective immediately and SCDHHS will be immediately notified of the termination and provided any information requested by SCDHHS.

D.1.3 HOLD HARMLESS

D.1.3.1 At all times during the term of this Subcontract, the Subcontractor shall, except as otherwise prohibited or limited by law, indemnify, defend, protect, and hold harmless SCDHHS and any of its officers, agents, and employees from:

D.1.3.1.1 Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for the Subcontractor in connection with the performance of this Subcontract;

D.1.3.1.2 Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by the Subcontractor, its agents, officers, employees, or subcontractors in the performance of this Subcontract;

D.1.3.1.3 Any claims for damages or losses resulting to any person or firm injured or damaged by Subcontractor, its agents, officers, employees, or subcontractors by the publication,

translation, reproduction, delivery, performance, use, or disposition of any data processed under this Subcontract in a manner not authorized by the MCO Contract or by federal or state regulations or statutes;

D.1.3.1.4 Any failure of the Subcontractor, its agents, officers, employees, or subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;

D.1.3.1.5 Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of SCDHHS in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

D.1.3.1.6 Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against SCDHHS or their agents, officers or employees, through the intentional conduct, negligence or omission of the Subcontractor, its agents, officers, employees or subcontractors.

D.1.3.2 As required by South Carolina law and/or the South Carolina Attorney General (SCAG), in circumstances where the Subcontractor is a political subdivision of the State of South Carolina, or an affiliate organization, except as otherwise prohibited by law, neither Subcontractor nor SCDHHS shall be liable for any claims, demands, expenses, liabilities and losses (including reasonable attorney's fees) which may arise out of any acts or failures to act by the other party, its employees or agents, in connection with the performance of services pursuant to this Subcontract.

D.1.3.3 It is expressly agreed that the Contractor, Subcontractor and agents, officers, and employees of the Contractor or Subcontractor in the performance of this Subcontract shall act in an independent capacity and not as officers and employees of SCDHHS. It is further expressly agreed that this Subcontract shall not be construed as a partnership or joint venture between the Contractor or Subcontractor and the Department and the State of South Carolina.

D.1.4 LAWS

D.1.4.1 The Subcontractor shall recognize and abide by all state and federal laws, regulations and SCDHHS's guidelines applicable to the provision of services under the Medicaid Managed Care Program.

D.1.4.2 The Subcontractor must comply with all applicable statutory and regulatory requirements of the Medicaid program, including applicable subregulatory guidance, and be eligible to participate in the Medicaid program.

D.1.4.3 This Subcontract shall be subject to and hereby incorporates by reference all applicable federal and state laws, regulations, policies, and revisions of such laws or regulations shall automatically be incorporated into the Subcontract as they become effective.

D.1.4.4 The Subcontractor represents and warrants that it has not been excluded from participation in the Medicare and/or Medicaid program pursuant to 42 U.S.C. §1320a-7 or 42 U.S.C. §1320c-5 or is not otherwise barred from participation in the Medicaid and/or Medicare program.

D.1.4.5 The Subcontractor also represents and warrants that it has not been debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

D.1.4.6 The Subcontractor shall not have had a contract with SCDHHS that was terminated, suspended, denied, or not renewed as a result of any action of Center for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services (HHS), or the Vulnerable Adults and Medicaid Provider Fraud (f/k/a Medicaid Fraud Unit) of the Office of the South Carolina Attorney General. If Subcontractor has been sanctioned by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and is currently under suspension, Subcontractor shall not be allowed to participate in the Medicaid Managed Care Program, and this Subcontract shall become immediately null and void. In the event the Subcontractor is suspended, sanctioned or otherwise excluded during the term of this Subcontract, the Subcontractor shall immediately notify the Contractor in writing.

D.1.4.7 The Subcontractor must ensure it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment,

consulting, or other agreement with debarred individuals for the provision of items and services that are significant to the Contractor's contractual obligation under the MCO Contract.

D.1.4.8 The Subcontractor shall check the Excluded Parties List Service administered by the General Services Administration, when it hires any employee or subcontracts with any subcontractor, to ensure that it does not employ individuals or use subcontractors who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other agreement with debarred individuals for the provision of items and services that are significant to Subcontractor's contractual obligation. The Subcontractor shall also report to the Contractor any employees or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

D.1.4.9 In accordance with 42 CFR 455.104 (2024, as amended), the Subcontractor agrees to provide full and complete ownership and disclosure information with the execution of this Subcontract if not enrolled with SCDHHS as a South Carolina Medicaid Network Provider and to report any ownership changes within thirty-five (35) days to the Contractor. Subcontractor must download the appropriate form from the Contractor's website or request a printed copy be sent. Failure by the Subcontractor to disclose this information may result in termination of this Subcontract.

D.1.4.10 It is mutually understood and agreed that all Subcontract language, specifically required by SCDHHS, shall be governed by the laws and regulations of the State of South Carolina both as to interpretation and performance by Subcontractor. The jurisdiction for any action at law, suit in equity, or judicial proceeding for the enforcement of SCDHHS required language shall be in the State of South Carolina, County of Richland.

D.1.5 AUDIT, RECORDS AND OVERSIGHT

D.1.5.1 The Subcontractor shall maintain an adequate record system for recording services, service Providers, charges, dates, and all other commonly accepted information elements for services rendered to Medicaid Members pursuant to this Subcontract (including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed).

D.1.5.2 SCDHHS, HHS, CMS, the U.S. Department of Health and Human Services (HHS) Office of Inspector General, the State Comptroller,

the State Auditor's Office, and the South Carolina Attorney General's (SCAG) Office, or any of their designees shall have the right to evaluate, through audit, inspection, or other means, whether announced or unannounced, any books, contracts, computer or other electronic systems of Subcontractor (or any subcontractor of Subcontractor) that pertain to any aspects of services and activities performed, or determination of amounts payable, under Contractor's Subcontract with the Subcontractor, including those pertaining to quality, appropriateness and timeliness of services.

D.1.5.2.1 The Subcontractor shall cooperate with these evaluations and inspections. The Subcontractor will make office workspace available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provision of services under this Subcontract. Subcontractor will make available, for purposes of an audit, evaluation or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid Members.

D.1.5.2.2 The right to audit Subcontractor will exist through ten (10) years from the final date of the MCO Contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Office of Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Office of Inspector General may inspect, evaluate, and audit the Subcontractor at any time.

D.1.5.3 The Subcontractor will allow SCDHHS and HHS, or their designee, to inspect and audit any financial records and/or books pertaining to: 1) the ability of the Subcontractor to bear the risk of financial loss; and 2) services performed or payable amounts under the Subcontract.

D.1.5.4 Whether announced or unannounced, the Subcontractor shall participate and cooperate in any internal and external quality assessment review, utilization management, and Grievance procedures established by the Contractor or its designee.

D.1.5.5 The Subcontractor shall comply with any plan of correction initiated by the Contractor and/or required by SCDHHS.

D.1.5.6 All records originated or prepared in connection with the Subcontractor's performance of its obligations under this Subcontract, including, but not limited to, working papers related to the preparation of fiscal reports, health records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the Subcontractor in accordance with the terms and conditions of this Subcontract. The Subcontractor agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Medicaid Members relating to the delivery of care or service under this Subcontract, and as further required by SCDHHS, for a period of ten (10) years from the expiration date of the MCO Contract, including any MCO Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the ten (10) year period, whichever is later. If Subcontractor stores records on microfilm or microfiche, the Subcontractor must produce, at its expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) days of the request. See 42 CFR 438.230(c)(3) (2024, as amended).

D.1.5.7 SCDHHS and/or any designee will also have the right to:

D.1.5.7.1 Inspect and evaluate the qualifications and certification or licensure of Subcontractor;

D.1.5.7.2 Evaluate, through inspection of Subcontractor’s facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of services under this Subcontract;

D.1.5.7.3 Audit and inspect any of Subcontractor’s records that pertain to health care or other services performed under this Subcontract, determine amounts payable under this Subcontract;

D.1.5.8 Subcontractor shall release health records of Medicaid Members, as may be authorized by the Medicaid Member or as may be directed by authorized personnel of SCDHHS, appropriate agencies of the State of South Carolina, or the United States Government. Release of health records shall be consistent with the provisions of confidentiality as expressed in this Subcontract.

D.1.6 SAFEGUARDING INFORMATION

D.1.6.1 The Subcontractor shall safeguard information about Medicaid Members according to applicable state and federal laws and regulations including but not limited to 42 CFR 431, Subpart F (2024, as amended) and the Health Insurance Portability and Accountability Act (as amended), and 45 CFR Parts 160 and 164 (2024, as amended).

D.1.6.2 The Subcontractor shall assure that all material and information, in particular information relating to Medicaid Members, which is provided to or obtained by or through the Subcontractor's performance under this Subcontract, whether verbal, written, electronic file, or otherwise, shall be protected as confidential information as required under state and federal laws and regulations. Subcontractor shall not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this Subcontract.

D.1.6.3 All information as to personal facts and circumstances concerning Medicaid Members obtained by the Subcontractor shall be treated as privileged communications, shall be held confidential, and shall not be divulged to third parties without the written consent of SCDHHS or the Medicaid Member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning Medicaid Members shall be limited to purposes directly connected with the administration of the MCO Contract.

Appendix E- Provider Agreement Boilerplate

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (SCDHHS)
REQUIRED PROVIDER AGREEMENT BOILERPLATE

The following language is required by SCDHHS as a condition of participation in the Medicaid program as a Participating Provider of the Contractor:

E.1 To the extent that any other provision of this Provider Agreement conflicts with any provision or requirement set forth within this Section, SCDHHS's required language shall be controlling. Any other provision in this Provider Agreement notwithstanding, in the event that SCDHHS shall modify, amend, or otherwise change the required Provider Agreement language, as set forth in the Contractor's managed care contract with SCDHHS (MCO Contract), Provider understands and agrees that the SCDHHS required Provider Agreement boilerplate shall be amended to conform to SCDHHS's requirements and standards, without the need for a signed, written amendment.

E.1.1 DEFINITIONS

SCDHHS requires that the defined terms provided below shall be used consistent with the definitions provided here throughout all documents related to the Medicaid Managed Care Program.

Action – As related to Grievance, either (1) the denial or limited authorization of a requested service, including the type or level of service; (2) the reduction, suspension, or termination of a previously authorized service; (3) the denial, in whole or in part, of payment for a service; (4) the failure to provide services in a timely manner, as defined by the Department; (5) the failure of the CONTRACTOR to act within the timeframes provided in *section 9.7.1* of the MCO Contract; or (6) for a resident of a rural area with only one CONTRACTOR, the denial of a Medicaid Managed Care Member's request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the CONTRACTOR's network.

Additional Services – A service(s) provided by the CONTRACTOR that is a non-covered service(s) by the South Carolina State Plan for Medical Assistance and is offered to Medicaid Managed Care Members in accordance with the standards and other requirements set forth in the Department's Medicaid Managed Care Contract that are outlined in another section of this Contract.

Administrative Services Contracts or Administrative Services Subcontracts – Are Subcontracts or agreement that include but are not limited to: 1) any function related to the management of the Medicaid Managed Care Contract with the Department; 2) Claims processing including pharmacy Claims; 3) credentialing including those for only primary source verification; 4) all Management Service Agreements; and 5) all Service Level Agreements (SLAs) with any Division of Subsidiary of a corporate parent owner.

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

Continuity of Care – The continuous treatment for a condition (such as pregnancy) or duration of illness from the time of first contact with a healthcare Provider through the point of release or long-term maintenance.

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

Emergency Services – Covered inpatient and outpatient services that are as follows: (1) furnished by a Provider that is qualified to furnish these services under Title 42 of the Code of Federal Regulations; and (2) needed to evaluate or stabilize an Emergency Medical Condition.

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

Grievance – An expression of dissatisfaction about any matter other than an Action. The term is also used to refer to the overall system that includes Grievances and appeals handled at the CONTRACTOR level. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Medicaid Managed Care Member's rights.)

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a Comprehensive Risk Contract that is (1) a Federally qualified HMO that meets the advance directive requirements of subpart I of 42 CFR Part 489; or (2) any public or private entity that meets the advance directives requirements and is determined to also meet the following conditions: (a) makes the services it provides to its Medicaid Managed Care Members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid recipients within the area serviced by the entity; and (b) meets the solvency standards of 42 CFR § 438.116. This includes any of the entity’s employees, affiliated Providers, agents, or CONTRACTORs.

Management Service Agreements – A type of Subcontract with an entity in which the CONTRACTOR delegates some or all of the comprehensive management and administrative services necessary for the operation of the CONTRACTOR.

Medically Necessary Service – Those medical services which: (a) are essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap, or result in illness or infirmity of a Medicaid Managed Care Member; (b) are provided at an appropriate facility and at the appropriate level of care for the treatment of the Medicaid Managed Care Member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

Medicaid Managed Care Member – An eligible person(s) who is enrolled with a Department approved Medicaid Managed Care Organization (MCO, a.k.a. CONTRACTOR). For purpose of this Subcontract, Medicaid Managed Care Member shall include the patient, parent(s), guardian, spouse, or any other person legally responsible for the Medicaid Managed Care Member being served.

Minimum Subcontract Provision (MSP) – Minimum Service Provisions are detailed in subsection D.2 below.

Primary Care Provider (PCP) – The Provider, serving as the entry point into the health care system, for the Medicaid Managed Care Member responsible for providing primary care, coordinating and monitoring referrals to specialist care, authorizing hospital services, and maintaining Continuity of Care.

Provider – In accordance with 42 CFR § 400.203 Definitions specific to Medicaid, any individual or entity furnishing Medicaid services under a Provider agreement with the CONTRACTOR or the Medicaid agency. These may include the following:

- Any individual, group, Physicians (such as but not limited includes Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Outpatient Center (free standing or owned) Clinics and Laboratories) furnishing Medicaid services under an agreement with the Medicaid agency; or
- For the Medicaid Managed Care Program, any individual, group, Physicians (including, but not limited to, Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Clinics, Outpatient Centers (free standing or owned) and Laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services.

Rural Health Clinic (RHC) – A South Carolina licensed Rural Health Clinic is certified by the Centers for Medicare and Medicaid Services and receiving Public Health Services grants. An RHC is eligible for state defined cost-based reimbursement from the Medicaid fee-for-service program. An RHC provides a wide range of primary care and enhanced services in a medically underserved area.

Service Level Agreement (SLA) – A type of Subcontract with a corporate owner or any of its Divisions or Subsidiaries that requires specific levels of service for administrative

functions or services for the CONTRACTOR specifically related to fulfilling the CONTRACTOR's obligations to the Department under the terms of this Contract.

South Carolina Medicaid Network Provider – A Provider of healthcare services or products which includes but is not limited to an institution, facility, agency, person, corporation, partnership, practitioner, specialty physician, group or association approved and enrolled by the South Carolina Department of Health and Human Services, licensed and/or credentialed which accepts as payment in full for providing benefits to Medicaid Managed Care Members amounts pursuant to the CONTRACTOR's reimbursement provisions, business requirements and schedules.

Subcontract – A written agreement between the CONTRACTOR and a third party to perform a part of the CONTRACTOR's obligations as specified under the terms of the MCO Contract.

Subcontractor – Any organization or person who provides any functions or service for the CONTRACTOR specifically related to securing or fulfilling the CONTRACTOR's obligations to Department under the terms of the MCO Contract.

E.1.2 ADMINISTRATIVE REQUIREMENTS

E.1.2.1 SCDHHS retains the right to review any and all Provider Agreements entered into for the provision of any services under the MCO Contract.

E.1.2.2 SCDHHS does not require the Provider to participate in any other line of business (i.e., Medicare Advantage or commercial) offered by the Contractor in order to enter into a business relationship with the Contractor.

E.1.2.3 The Department does not require the Provider to participate in the network of any other Managed Care Organization as a condition of doing business with Contractor.

E.1.2.4 The Contractor and the Provider shall be responsible for resolving any disputes that may arise between the two (2) parties, and no dispute shall disrupt or interfere with the Continuity of Care of a Medicaid Member. Provider recognizes and agrees that it does not have a right to a state fair hearing before SCDHHS's Division of Appeals and Hearings.

E.1.2.5 The Provider represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. The Provider further covenants that, in the performance of this Provider Agreement, no person having any such known interests shall be employed.

E.1.2.6 The Provider recognizes that in the event of termination of the MCO Contract, the Contractor is required to make available to SCDHHS, or its designated representative, in a usable form, any and all records, whether medical or financial, related to the Contractor's and Provider's activities undertaken pursuant to this Provider Agreement. The Provider agrees to furnish any records to the Contractor that the Contractor would need in order to comply with this provision. The provision of such records shall be at no expense to SCDHHS.

E.1.2.7 SCDHHS must be notified of the intent to terminate this Provider Agreement one hundred twenty (120) days prior to the effective date of termination. The date of termination will be at midnight on the last day of the month of termination.

E.1.2.8 If the termination of this Provider Agreement is as a result of a condition or situation that would have an adverse impact on the health and safety of Medicaid Members, the termination shall be effective immediately and SCDHHS will be immediately notified of the termination and provided any information requested by SCDHHS.

E.1.2.9 The Contractor and Provider shall develop, maintain, and use a system for Prior Authorization and utilization management that is consistent with this Provider Agreement.

E.1.3 HOLD HARMLESS

E.1.3.1 At all times during the term of this Provider Agreement, the Provider shall, except as otherwise prohibited or limited by law, indemnify, defend, protect, and hold harmless SCDHHS and any of its officers, agents, and employees from:

E.1.3.1.1 Any claims for damages or losses arising from services rendered by any Provider, person, or firm performing or supplying services, materials, or supplies for the Provider in connection with the performance of this Provider Agreement;

E.1.3.1.2 Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of state or federal Medicaid regulations or legal statutes, by the Provider, its agents, officers, employees, or Subcontractors in the performance of this Provider Agreement;

E.1.3.1.3 Any claims for damages or losses resulting to any person or firm injured or damaged by Provider, its agents, officers, employees, or Subcontractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Provider Agreement in a manner not authorized by the MCO Contract or by federal or state regulations or statutes;

E.1.3.1.4 Any failure of the Provider, its agents, officers, employees, or Subcontractors to observe the federal or state laws, including, but not limited to, labor laws and minimum wage laws;

E.1.3.1.5 Any claims for damages, losses, or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of SCDHHS in connection with the defense of claims for such injuries, losses, claims, or damages specified above;

E.1.3.1.6 Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against SCDHHS or their agents, officers or employees, through the intentional conduct, negligence or omission of the Provider, its agents, officers, employees or Subcontractors.

E.1.3.2 As required by South Carolina law and/or the South Carolina Attorney General (SCAG), in circumstances where the Provider is a political subdivision of the State of South Carolina, or an affiliate organization, except as otherwise prohibited by law, neither Provider nor SCDHHS shall be liable for any claims, demands, expenses, liabilities and losses (including reasonable attorney's fees) which may arise out of any acts or failures to act by the other party, its employees or agents, in connection with the performance of services pursuant to this Provider Agreement.

E.1.3.3 It is expressly agreed that the Contractor, Provider and agents, officers, and employees of the Contractor or Provider in the performance of this Provider Agreement shall act in an independent capacity and not as officers and employees of SCDHHS or the State of South Carolina. It is further expressly agreed that this Provider Agreement shall not be construed as a partnership or joint venture between the Contractor or Provider and SCDHHS and the State of South Carolina.

E.1.4 LAWS

E.1.4.1 The Provider shall recognize and abide by all state and federal laws, regulations and SCDHHS's guidelines applicable to the provision of services under the Medicaid Managed Care Program.

E.1.4.2 The Provider must comply with all applicable statutory and regulatory requirements of the Medicaid program, including applicable subregulatory guidance, and be eligible to participate in the Medicaid program.

E.1.4.3 This Provider Agreement shall be subject to and hereby incorporates by reference all applicable federal and state laws, regulations, policies, and revisions of such laws or regulations shall automatically be incorporated into the Provider Agreement as they become effective.

E.1.4.4 The Provider represents and warrants that it has not been excluded from participation in the Medicare and/or Medicaid program pursuant to 42 U.S.C. §1320a-7 or 42 U.S.C. §1320 c-5 or is not otherwise barred from participation in the Medicaid and/or Medicare program.

E.1.4.5 The Provider also represents and warrants that it has not been debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

E.1.4.6 The Provider shall not have a Medicaid contract with SCDHHS that was terminated, suspended, denied, or not renewed as a result of any action of Center for Medicare and Medicaid Services (CMS), United States Department of Health and Human Services (HHS), or the Vulnerable Adults and Medicaid Provider Fraud (f/k/a Medicaid Fraud Unit) of the Office of the South Carolina Attorney General. If Provider has been sanctioned by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and is currently under suspension, Provider shall not be allowed to participate in the Medicaid Managed Care Program, and this Provider Agreement shall become immediately null and void. In the event the Provider is suspended, sanctioned or otherwise excluded during the term of this Provider Agreement, the Provider shall immediately notify the Contractor in writing.

E.1.4.7 The Provider ensures that it does not employ individuals who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other contract with debarred individuals for the

provision of items and services that are significant to the Contractor's contractual obligation under the MCO Contract.

E.1.4.8 The Provider shall check the Excluded Parties List Service administered by the General Services Administration, when it hires any employee or contracts with any Subcontractor, to ensure that it does not employ individuals or use Subcontractors who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other contract with debarred individuals for the provision of items and services that are significant to Provider's contractual obligation. The Provider shall also report to the Contractor any employees or Subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

E.1.4.9 In accordance with 42 CFR 455.104 (2024, as amended), the Provider agrees to provide full and complete ownership and disclosure information with the execution of this Provider Agreement if not enrolled with SCDHHS as a South Carolina Medicaid Network Provider and to report any ownership changes within thirty-five (35) days to the Contractor. Provider must download the appropriate form from the Contractor's website or request a printed copy be sent. Failure by the Provider to disclose this information may result in termination of this Provider Agreement.

E.1.4.10 It is mutually understood and agreed that all contract language, specifically required by SCDHHS, shall be governed by the laws and regulations of the State of South Carolina both as to interpretation and performance by Provider. The jurisdiction for any action at law, suit in equity, or judicial proceeding for the enforcement of SCDHHS required language shall be in the State of South Carolina, County of Richland.

E.1.5 AUDIT, RECORDS AND OVERSIGHT

E.1.5.1 The Provider shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly accepted information elements for services rendered to Medicaid Members pursuant to this Provider Agreement (including, but not limited to, such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed). Medicaid Members and their authorized representatives shall be given access to and can request copies of

the Medicaid Members' health records, to the extent and in the manner provided by S.C. Code Ann. §44-115-10 et seq., (2018, as amended).

E.1.5.2 SCDHHS, HHS, CMS, the U.S. Department of Health and Human Services (HHS) Office of Inspector General, the State Comptroller, the State Auditor's Office, and the South Carolina Attorney General's (SCAG) Office, or any of their designees shall have the right to evaluate, through audit, inspection, or other means, whether announced or unannounced, any books, contracts, computer or other electronic systems of Provider (or any subcontractor of Provider) that pertain to any aspects of services and activities performed, or determination of amounts payable, under Contractor's Provider Agreement with the Provider, including those pertaining to quality, appropriateness and timeliness of services and the timeliness and accuracy of encounter data and claims submitted to the Contractor.

E.1.5.2.1 The Provider shall cooperate with these evaluations and inspections. The Provider will make office workspace available for any of the above-mentioned entities or their designees when the entities are inspecting or reviewing any records related to the provision of services under this Provider Agreement. Provider will make available, for purposes of an audit, evaluation or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid Members.

E.1.5.2.2 The right to audit Provider will exist through ten (10) years from the final date of the MCO Contract period or from the date of completion of any audit, whichever is later. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Provider at any time.

E.1.5.3 The Provider will allow SCDHHS and HHS, or their designee, to inspect and audit any financial records and/or books pertaining to:

1) the ability of the Provider to bear the risk of financial loss; and
2) services performed or payable amounts under the Provider Agreement.

E.1.5.4 Whether announced or unannounced, the Provider shall participate and cooperate in any internal and external quality assessment

review, utilization management, and Grievance procedures established by the Contractor or its designee.

E.1.5.5 The Provider shall comply with any plan of correction initiated by the Contractor and/or required SCDHHS.

E.1.5.6 All records originated or prepared in connection with the Provider's performance of its obligations under this Provider Agreement, including, but not limited to, working papers related to the preparation of fiscal reports, health records, progress notes, charges, journals, ledgers, and electronic media, will be retained and safeguarded by the Provider in accordance with the terms and conditions of this Provider Agreement. The Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Medicaid Members relating to the delivery of care or service under this Provider Agreement, and as further required by SCDHHS, for a period of ten (10) years from the expiration date of the MCO Contract, including any MCO Contract extension(s). If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the ten (10) year period, whichever is later. If Provider stores records on microfilm or microfiche, the Provider must produce, at its expense, legible hard copy records upon the request of state or federal authorities, within fifteen (15) days of the request.

E.1.5.7 SCDHHS and/or any designee will also have the right to:

E.1.5.7.1 Inspect and evaluate the qualifications and certification or licensure of Provider;

E.1.5.7.2 Evaluate, through inspection of Provider’s facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to Medicaid Members;

E.1.5.7.3 Audit and inspect any of Provider’s records that pertain to health care or other services performed under this Provider Agreement, determine amounts payable under this Provider Agreement;

E.1.5.7.4 Audit and verify the sources of encounter data and any other information furnished by Provider or Contractor in response to reporting requirements of this Provider

Agreement or the MCO Contract, including data and information furnished by Provider.

E.1.5.8 Provider shall release health records of Medicaid Members, as may be authorized by the Medicaid Member or as may be directed by authorized personnel of SCDHHS, appropriate agencies of the State of South Carolina, or the United States Government. Release of health records shall be consistent with the provisions of confidentiality as expressed in this Provider Agreement.

E.1.5.9 Provider shall maintain up-to-date health records at the site where medical services are provided for each Medicaid Member for whom services are provided under this Provider Agreement. Each Medicaid Member's record must be legible and maintained in detail consistent with good medical and professional practice that permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. SCDHHS's representatives or designees shall have immediate and complete access to all records pertaining to the health care services provided to the Medicaid Member.

E.1.6 BILLING A MEDICAID MEMBER

E.1.6.1 The Subcontractor may bill a Medicaid Member only under the following circumstances:

E.1.6.1.1 Provider is a provider of services and is seeking to render services that are non-covered services and are not Additional Services, as long as the Provider provides to the Medicaid Member a written statement of the services prior to rendering said services. This written statement must include: (1) the cost of each service, (2) an acknowledgement of the Medicaid Member's responsibility for payment, and (3) the Medicaid Member's signature; or

E.1.6.1.2 Provider is a provider of services, and the service provided has a Co-payment, as allowed by the Contractor. The Provider may charge the Medicaid Member only the amount of the allowed Co-payment, which cannot exceed the Co-payment amount allowed by SCDHHS.

E.1.6.2 In accordance with the requirements of S.C. Code Ann. §38-33-130(B) (2015, as amended), and as a condition of participation as a South Carolina Medicaid Network Provider, the Provider hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have

recourse against, a Medicaid Member, or persons acting on their behalf, for health care services which are rendered to such Medicaid Member by the Provider, and which are covered benefits under the Medicaid Member's Evidence of Coverage. This provision applies to all covered health care services furnished to the Medicaid Member for which SCDHHS does not pay the Contractor or the Contractor does not pay the Provider. Provider agrees that this provision is applicable in all circumstances including, but not limited to, non-payment by the Contractor and insolvency of the Contractor. The Provider further agrees that this provision shall be construed to be for the benefit of Medicaid Member and that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and such Medicaid Member.

E.2 PROVIDER SUBCONTRACTOR BOILERPLATE

E.2.1 HEALTHCARE SERVICES

E.2.1.1 The Provider shall ensure adequate access to the services provided under this Provider Agreement in accordance with the prevailing medical community standards.

E.2.1.2 The services covered by this Provider Agreement must be in accordance with the South Carolina State Plan for Medical Assistance under Title XIX of the Social Security Act, and the Provider shall provide these services to Medicaid Members through the last day that this Provider Agreement is in effect. All final Medicaid benefit determinations are within the sole and exclusive authority of SCDHHS or its designee.

E.2.1.3 The Provider may not refuse to provide Medically Necessary Services or covered preventive services to Medicaid Members for non-medical reasons.

E.2.1.4 The Provider shall render Emergency Services without the requirement of Prior Authorization of any kind.

E.2.1.5 The Provider shall not be prohibited or otherwise restricted from advising a Medicaid Member about the health status of the Medicaid Member or medical care or treatment for the Medicaid Member's condition or disease, regardless of whether benefits for such care or treatment are provided under the MCO Contract, if Provider is acting within the lawful scope of practice.

E.2.1.6 This Provider Agreement shall not include any covenant-not-to-compete requirements or exclusive provider clauses. Specifically,

the Contractor is precluded from requiring that the Provider not provide services for any other South Carolina Medicaid MCO. In addition, this Provider Agreement shall not contain compensation terms that discourage Provider from serving any specific eligibility category.

E.2.1.7 The Provider must take adequate steps to ensure that Medicaid Members with limited English skills receive, free of charge, the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Contract in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (as amended) and it's implementing regulation at 45 CFR Part 80 (2024, as amended).

E.2.1.8 The Provider shall provide effective Continuity of Care activities, if applicable, that seek to ensure that the appropriate personnel, including the PCP are kept informed of the Medicaid Member's treatment needs, changes, progress, or problems.

E.2.1.9 The Provider must adhere to the Quality Assessment Performance Improvement and Utilization Management (UM) requirements consistent with the MCO Contract. The Contractor is responsible for informing the Provider of such requirements and procedures, including any reporting requirements.

E.2.1.10 The Provider shall have an appointment system for Medically Necessary Services that is in accordance with the standards in the MCO Contract and prevailing medical community standards.

E.2.1.11 The Provider shall not use discriminatory practices with regard to Medicaid Members such as separate waiting rooms, separate appointment days, or preference to private pay patients.

E.2.1.12 The Provider must identify Medicaid Members in a manner that will not result in discrimination against the Medicaid Member in order to provide or coordinate the provision of all covered services and/or Additional Services and out of plan services.

E.2.1.13 The Provider agrees that no person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of the Contractor's Plan or be otherwise subjected to discrimination in the performance of this Provider Agreement or in the employment practices of the Provider. The Provider shall show proof of such non-discrimination, upon request, and shall post in conspicuous places,

available to all employees and applicants, notices of non-discrimination.

E.2.1.14 If the Provider performs laboratory services, the Provider must meet all applicable state and federal requirements related thereto. All laboratory-testing sites providing services shall have either a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

E.2.1.15 If the Provider is a hospital, Provider shall notify the Contractor and SCDHHS of the births when the mother is a Medicaid Member. The Provider shall also complete a SCDHHS request for Medicaid ID Number (Form 1716 ME), including indicating whether the mother is a Medicaid Member, and submit the form to the local/state SCDHHS office.

E.2.1.16 If the Provider is an FQHC/RHC, Provider shall adhere to federal requirements for reimbursement for FQHC/RHC services. This Provider Agreement shall specify the agreed upon payment from the Contractor to the FQHC/RHC. Any bonus or incentive arrangements made to the FQHCs/RHCs associated with Medicaid Members must also be specified and included this Provider Agreement.

E.2.1.17 If the Provider is a PCP, the Provider shall have an appointment system for covered services and/or Additional Services that is in accordance with prevailing medical community standards but shall not exceed the following requirements:

E.2.1.17.1 Routine visits scheduled within fifteen (15) Business days.

E.2.1.17.2 Urgent, non-emergency visits within forty-eight (48) hours.

E.2.1.17.3 Emergent or emergency visits immediately upon presentation at a service delivery site.

E.2.1.17.4 Waiting times that do not exceed forty-five (45) minutes for a scheduled appointment of a routine nature.

E.2.1.17.5 Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

E.2.1.17.6 Walk-in patients with urgent needs should be seen within forty-eight (48) hours.

E.2.1.18 As a PCP, the Provider must also provide twenty-four (24) hour coverage but may elect to provide twenty-four (24) hour coverage by direct access or through arrangement with a triage system. The triage system arrangement must be prior approved by the Contractor.

E.2.1.19 The Provider shall submit all reports and clinical information required by the Contractor, including Early Periodic Screening, Diagnosis, and Treatment (EPSDT), if applicable.

E.2.2 PAYMENT

E.2.2.1 Contractor, or its designee, shall be responsible for payment of services rendered to Medicaid Members in accordance with this Provider Agreement and shall pay ninety percent (90%) of all Clean Claims from practitioners, either in individual or group practice or who practice in shared health facilities, within thirty (30) days of the date of receipt. The Contractor shall pay ninety-nine percent (99%) of all Clean Claims from practitioners, either in individual or group practice or who practice in shared health facilities, within ninety (90) days of the date of receipt. The date of receipt is the date the Contractor receives the claim, as indicated by its data stamp on the claim. The date of payment is the date of the check or other form of payment.

E.2.2.2 The Contractor and Provider may, by mutual written agreement, establish an alternative payment schedule to the one presented above.

E.2.2.3 The Provider shall accept payment made by the Contractor as payment-in-full for covered services and Additional Services provided and shall not solicit or accept any surety or guarantee of payment from the Medicaid Care Member, except as specifically allowed by Billing of Medicaid Members as stated above.

E.2.2.4 No Provider Agreement shall contain any provision that provides incentives, monetary or otherwise, for the withholding of Medically Necessary Services.

E.2.2.5 Any incentive plans for Providers shall be in compliance with 42 CFR 438.3(i) (2024, as amended), referencing 42 CFR 422.208 and 42 CFR 422.210 (2024, as amended).

Appendix F. BABYNET

F.1 PURPOSE

In addition to the Medicaid program the South Carolina Department of Health and Human Services administers the State of South Carolina's Early Intervention System under Part C of the Individuals with Disabilities Education Act (IDEA Part C) heretofore referred to as BabyNet.

For children from birth to age three (3) meeting BabyNet eligibility criteria, the early intervention services offered in the program build upon and provide supports and resources to assist and enhance the learning and development of infants and toddlers with disabilities and special needs. Children who participate in the BabyNet program may also be eligible for full Medicaid benefits.

The CONTRACTOR will be responsible for services listed in this appendix for children that are eligible for full Medicaid and BabyNet services when a child qualifies for both programs. An Individualized Family Service Plan (IFSP) is created for each child meeting BabyNet eligibility criteria. This plan determines the services each child requires to meet the requirements of the IDEA Part C. The services set forth in the IFSP may be a combination of both medically necessary services covered under Medicaid along with services necessary to meet the requirements of the IDEA Part C. When the IFSP sets forth Additional Services that are not medically necessary under Medicaid (Title XIX) coverage those services are provided to children meeting BabyNet eligibility criteria under IDEA Part C and after the Medicaid benefit has been fully exhausted by the child.

F.2 DEFINITIONS

F.2.1 Audiology Evaluation and Services - Identification of children with auditory impairments, using at-risk criteria and appropriate audiologic screening techniques; (ii) Determination of the range, nature, and degree of hearing loss and communication functions, by use of audiological evaluation procedures; (iii) Referral for medical and other services necessary for the habilitation or rehabilitation of an infant or toddler with a disability who has an auditory impairment; (iv) Provision of auditory training, aural rehabilitation, speech reading and listening devices, orientation and training, and other services; (v) Provision of services for prevention of hearing loss; and (vi) Determination of the child's individual amplification, including selecting, fitting, and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

F.2.2 Autism Services - Services utilizing highly structured and intensive skill-oriented training sessions to help children develop social and language skills, such as applied behavioral analysis, which encourages positive behaviors and discourages negative ones.

F.2.3 BabyNet – South Carolina's interagency early intervention system operated under Part C of the Individuals with Disabilities Education Act (IDEA Part C) for

infants and toddlers under three (3) years of age with developmental delays, or who have conditions associated with developmental delays.

F.2.4 CONTRACTOR – The domestic licensed HMO ("MCO") that has executed a formal agreement with the Department to enroll and serve Medicaid Managed Care Program members under the terms of this contract. The term CONTRACTOR shall include all employees, Subcontractors, agents, volunteers, and anyone acting on behalf of, in the interest of, or for a CONTRACTOR.

F.2.5 Department – For the purposes of this contract, the term "Department" is used in reference to the South Carolina Department of Health and Human Services (SCDHHS).

F.2.6 Individualized Family Service Plan (IFSP) – An IFSP is a multidisciplinary plan that captures the strengths and needs of the child and his or her family and outlines the services necessary to address the child's developmental delays or disabilities. An IFSP only applies to children from birth to three (3) years of age.

F.2.7 Medicaid – The medical assistance Program authorized by Title XIX of the Social Security Act.

F.2.8 Occupational Therapy – Services utilized to address the functional needs of children from birth to three (3) years of age with a disability related to adaptive development, adaptive behavior and play and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings and include:

1. Identification, assessment, and intervention;
2. Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
3. Prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

F.2.9 Physical Therapy – includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation. These services include—

1. Screening, evaluation, and assessment of children to identify movement dysfunction;
2. Obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and
3. Providing services or treatment to prevent, alleviate, or compensate for, movement dysfunction and related functional problems.

F.2.10 Speech-language Services –

1. Identification of children with communication or language disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills;
2. Referral for medical or other professional services necessary for the habilitation or rehabilitation of children with communication or language disorders and delays in development of communication skills; and
3. Provision of services for the habilitation, rehabilitation, or prevention of communication or language disorders and delays in development of communication skills.

F.2.11 Vision Services –

1. Evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays, and abilities that affect early childhood development;
2. Referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders, or both; and
3. Communication skills training, orientation and mobility training for all environments, visual training, and additional training necessary to activate visual motor abilities.

F.3 CONTRACTOR Responsibilities:

F.3.1 Accept all BabyNet approved Individualized Family Service Plan services in a format specified by the Department.

F.3.1.1 Authorize all audiology evaluations and services in the amount, duration, and scope in the child's current IFSP.

F.3.1.2 Authorize all autism services in the amount, duration, and scope in the child's current IFSP.

F.3.1.3 Authorize all occupational therapy services in the amount, duration and scope outlined in the child's current IFSP.

F.3.1.4 Authorize all physical therapy services in the amount, duration and scope outlined in the child's current IFSP.

F.3.1.5 Authorize all speech language pathology services in the amount, duration and scope outlined in the child's current IFSP.

F.3.1.6 Authorize all vision services in the amount, duration and scope outlined in the child's current IFSP.

F.4 TERM AND TERMINATION

F.4.1 The terms of this Appendix shall be effective immediately upon award of the Contract and shall terminate only when the condition(s) set forth in *Section 17* have been met by both the CONTRACTOR and Department.

F.5 MISCELLANEOUS

F.5.1 The parties agree to amend this Appendix as necessary to comply with terms of IDEA Part C, Medicaid regulations, and any other applicable law.