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Date	Section(s)	Page(s)	Change
12-15-14	**-**	**-**	****New** MCO Policies and Procedures effective July 1, 2014**
06-01-14	Appendix 5	134	Revised Withhold for Quality Performance Measures
05-01-14	5.4	30	Revised Managed Care Enrollment Period
	10.11	44	Revised Home Health Services
	10.27	53-54	Revised Substance Abuse Services
	Appendix 5	130	Revised Centering Program
01-01-14	10.26	53	Revised Vision Care Services
11-01-13	Cover		Replaced SCHC logo and remove MCO logo
	3.2	21	Added new section Enrollment Broker Updates for Managed Care Organizations
	4.2	25	Revised MCO Credentialing Committee and the Credentialing Process
	15.0	79-91	Revised Program Integrity Policies and Procedures – Managed Care Fraud and Abuse Complaints and Referrals
	25.0	106, 110 107 109	• Added definitions for Medicaid Fraud Control Unit (MFCU) and Surveillance and Utilization Surveillance and Utilization Review System (SURS) • Moved Member Handbook definition beneath Medicare • Revised Protected Health Information (PHI) definition
09-01-13	6.7	34-35	Revised FQHC/RHC Wrap Payment Process

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Date	Section(s)	Page(s)	Change
	10.9	43	Revised Family Planning
	Appendix 5	119 125 125	• Revised provider designated and MCO designated incentives • Revised Withhold for quality Performance Measures • Disposition of Undistributed Withhold Funds
08-01-13	2.0	4, 5	Added form number to Disclosure of Ownership and Control Interest Statement
	2.1	5	Revised Required Submissions
	10.25	51	Revised Transplant and Transplant-Related Services
	10.27	52	Added Substance Abuse Services
	13.0	59	Revised Quality Assessment and Utilization Management Requirements
	14.1-Appendix 4	73, 74, 76, 94, 109	Replaced "Certificate of Evidence of Coverage" with "Member Handbook"
	Appendix 5	118, 120	• Revised Patient Centered Medical Home (PCMH) • Revised Centering Pregnancy Incentive (formerly Centering Program)
05-30-13	Appendix 5	117	Revised Patient Centered Medical Home (PCMH)
05-24-13	6.7	34	Revised Background Information
	7.0	34	Revised Grievance (Complaint)
	14.3	73	Revised Beneficiary Marketing and Member Education Materials/Media

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Date	Section(s)	Page(s)	Change
	20.0	90	Removed Daily Newborn Enrollee file from Summary of Required Files, Reports, and Forms tables
	21.1	91	Revised the definition of beneficiary
	Appendix 5	117	Revised Patient Centered Medical Home (PCMH)
	19.0	86-87	Revised Pay for Performance Process (CRCS Reporting)
	Appendix 5	122	Revised penalty for low performance measurements
03-12-13	4.1	23	Revised Initial Credentialing and Recredentialing Policy
	11.1	52	Revised Mental Health Authorization or Provided by State Agencies
	Appendix 5	117 122	• Revised Patient Centered Medical Home (PCMH) • Revised Withhold for Quality Performance Measures
03-01-13	2.7	9-10	Revised New Boilerplate Subcontract
	2.8	10	Revised Contract Update Process
	2.9	10	Revised MCO Communications to Providers
	2.11	13	Corrected Specialists table entries
	4.2	24-26	Revised MCO Credentialing Committee and the Credentialing Process
	6.1	33	Revised Retrospective Review and Recoupment – Dual Eligible

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Date	Section(s)	Page(s)	Change
	6.8	34	Added **new** section: Affordable Care Act (ACA) Primary Care Enhanced Payments for Eligible Primary Care Physicians
	10.21	49	Revised Prescription Drugs
	10.25	52	Revised Transplant and Transplant-Related Services
	10.27	53	Deleted section for DAODAS (Alcohol and Drug Abuse Services)
	11.1	53	Changed section heading to Mental Health and Alcohol and Other Drug Abuse Treatment Services Authorized or Provided by State Agencies
	11.8	56	MAPPS Family Planning Services
	14.4	75	Revised General Marketing/Advertising and Medicaid MCO Member Education Policies
	18.1	86	Revised section heading to Pay for Performance (CRCS Reporting)
	19.0	87	Revised Summary of Required Files, Reports, and Forms table
	20.0	88	Revised definition for SCDHHS
	Appendix 5	117-123	Revised Incentives and Withholds Requirements
	Appendix 6	123-124	Revised Quality Weighted Auto Assignments
01-01-12	10.27	53	Added **new** section for DAODAS (Alcohol and Drug Abuse Services)
	11.1	54	Removed DAODAS language from Mental Health section

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Date	Section(s)	Page(s)	Change
	19.0	89	Revised Pay for Performance language
	Appendix 5		Revised Appendix 5 – Incentives and Withhold language
11-20-12	Appendices 5, 6	-	Complete revision
10-01-12	2.1	5	Updated contract section numbers
	2.10	12	Added reference to Appendix 5
	5.2	27	Deleted How is Medicaid Eligibility Determined? section
	5.3	27	Deleted Infants and Medicaid Eligibility section
	5.4	28	Deleted Annual Review – Medicaid Eligibility Redetermination section
	5.5	31	• Added policy MCOs may contact new members upon receipt of the monthly member listing file • Changed the number of days institutionalized in a LTC/nursing facility to 90 **continuous** days
	6.1	34	For retro-Medicare members, changed the timeframe to recoup provider payments from twenty-27 months to twelve (12) months
	7.0	35	Added new section Grievance (Complaint)
	8.0	35	• Changed heading to Appeals and State Fair Hearings formerly Grievance and Appeals • Updated policy throughout section
	9.0	27	Updated the following policy: • Expedited Authorization Decisions • Universal PA Medications Form

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Date	Section(s)	Page(s)	Change
	10.12.2	45	Deleted Sterilization note
	10.12.3	46	Added sterilization to as a service not offered as a Core Benefit
	11.1	53	Deleted Institutional Long-Term Care Facilities/Nursing Homes - Limitations section
	13.0	60 65 66	• Added Quality Assessment Program description • Change submission of Encounter Data to semimonthly • Added MCO member contact procedure when resolving grievances • Specify MCOs must use a spreadsheet to record the activities of the grievance and appeal system
	14.0	68	• Updated first paragraph to include changes in marketing plan submission and plan details • Removed Healthy Connections Choices telephone number
	14.1	70	• Added 30-day timeframe for an MCO appeal • Change marketing materials from "gifts" to "giveaway" items or value-added times and services • Added policy for gift cards
	14.2	72	• Change inappropriate contact with disenrollee to include indirect or third-party vendor
	14.5	75	• Added telephonic and social media surveys • Changed submission of results to 45 **calendar** days
	14.7	77 78	• Changed policy to members must use SCDHHS issued Medicaid cards • Added SC Healthy Connections Logo must be in color and show Medicaid identification number

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Date	Section(s)	Page(s)	Change
	16.0	82	• Changed disclosure form number to 1514 • Added policy MCOs must use form 1514 by April 1, 2013
	19.0	88	Added CRCS Reporting to heading
	20.0	90	Added Quality Initiatives to table of required files, reports, and forms
	21.0	94 95	• Added age limit for EPSDT • Updated Grievance definition
	Appendix 5	119-122	Revised Incentives and Withholds Requirements
	Appendix 6	123-125	Revised entire section
07-01-12	-	-	****New** MCO Policies and Procedures effective July 1, 2012**
	2.11	15	Long-Term Care - Changed the number of days institutionalized in an LTC/nursing facility to 90 days and the MCO liability to 120 days
	3.0, 3.1	20	Changed the reimbursement for additional cost incurred due to Network Termination or Transition to "incremental cost"
	5.8	33	Changed the number of days institutionalized in an LTC/nursing facility to 90 days
	8.0	38	Updated Expedited Authorization Decision policy to • Changed services received by member entering an MCO the day before enrollment to all medical services
	9.2	41	Updated to remove outpatient services from covered ancillary medical services

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Date	Section(s)	Page(s)	Change
	9.15	48	Changed the number of days institutionalized in a LTC/nursing facility to 90 days and the MCO liability to 120 days
	9.21	51	Added language to support the Universal PA Medication form implementation on October 1, 2012
	10.1	54	Changed the number of days institutionalized in a LTC/nursing facility to 90 days and the MCO liability to 120 days
	10.7	58	Added pervasive developmental disorders and Medically Complex Children's waiver to list of current special needs waivers
	12.1	69-70	• Removed HEDIS 2010 Technical Specification format requirement • Added requirement to obtain NCQA accreditation by 2015
	13.0	70-71	• Added requirement to submit marketing plan to SCDHHS in accordance with section 7.2 of the MCO Contract • Updated marketing/advertising material requirements
	20.0	95 103	• Added definition for Contracted Provider • Added definition for Value Added Items and Services (VAIS)
	Appendix 3	106	Updated Transportation Broker Listing and Contact Information
	Appendix 5	119-121	Updated entire section
	Appendix 6	122-155	Updated entire section and added Milliman SAS coding logic

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Date	Section(s)	Page(s)	Change
06-01-12	1.0	3	Added Corrective Action Plan (CAP) policy
	9.1.2	42	Added Back Transfers section
04-01-12	2.3	7	Deleted requirement for one (1) PCP per 2500 Medicaid MCO members
	2.11	14	• Added the following network providers to the subcontractor spreadsheet: Licensed Independent Social Worker, Licensed Professional Counselor, Licensed Marriage & Family Therapist, and Psychologist • Changed Psychiatry (private) status from 3 to 1
	6.1	34	Deleted Low Birth Weight and Very Low Birth Weight Kicker Payment Process section
	9.19	49	Remove mental health, therapeutic, and rehabilitative services language
	9.20	49	Removed payment language for medical services provided by psychiatrist or child psychiatrist
	9.23	51	Renamed heading and updated language for psychiatric services
	10.2	53	Changed heading and language to include services authorized or provided by state agencies
	10.2.1	53	Deleted – Hospital Services (UB-04 Claims)
	10.2.2	53	Deleted – Physicians/Clinic (CMS-1500 Claims)

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Date	Section(s)	Page(s)	Change
	12.0	65	Changed the age for recording immunization status in the pediatric record to under the age of 19
	Appendix 4	106 112, 115, 117,	• Added definition of a clean claim • Updated language in the following requirements: D.8, E.10, G.8, H.2, H.3
02-01-12	7.0	40	Updated working and added a paragraph to Grievances and Appeals
	2.7	10	Removed options for New Boilerplate Subcontract
	4	23	Updated outpatient hospital provider information
12-01-11	2.7	10-11	Added additional subcontractor boilerplate requirements
	13.6	81-82	• Changed section name to "Focus Group and Member Surveys • Updated section to include member survey language
	14	110-120	Added Appendix 4, Subcontract Boilerplate Requirements
11-01-11	Table of Contents	-	Updated to reflect reorganization of the document
	1.0, 2.0	2-4	Changed "Division of Care Management" to "Division of Managed Care"
	2.10	12	Added language to ensure MCOs receive approval by county for each provider network from SCDHHS before executing contracts

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Date	Section(s)	Page(s)	Change
	2.12	17	Added Requirements for the Utilization of Nurse Practitioners (NPs) as Providers of Health Care Services section
	3.0	19-20	Updated network termination and transition language
	3.1	20-21	Added Voluntary Termination of a County(ies) section
	4.0–4.2	21-26	Updated provider certification and licensing language
	9.0–9.25	41-56	Rearranged and revised Core Benefits section
	14.0–14.2	83-84	Renamed section heading and revised language
	18.0	92	Changed claims completeness rate to 97 % instead of 95 %
	20.0	96, 97, 101, 102	Added the following definitions: • Certified Nurse Midwife/Licensed Midwife • Certified Registered Nurse Anesthetist (CRNA)/Anesthesiologist Assistant (AA) • Medical Doctor • Nurse Practitioner and Clinical Nurse Specialist • Physician's Assistant
08-01-11	6.0	33	Added paragraph for the Universal 17-P Universal Authorization form
	19.0	95	Updated second paragraph for monthly files/reports
06-01-11	7.1	35	Updated first paragraph of Current Medicaid Service Limitations
	7.3	35	Updated first paragraph of Kidney section

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Date	Section(s)	Page(s)	Change
	18.0	94	Changed heading from “Pay for Reporting Process” to ”Pay for Performance Process” and updated section language
	19.0	95	Updated Index of Required Files, Reports, and Forms section, paragraph. 2
05-01-11	2.3	8	Added new paragraph at the end of the section to include MCO redetermination policy
	3.8	25	Deleted bullet #2 to remove language allowing MCOs to disenrollment a Medicaid MCO Member due to the member’s failure to follow the rules of the Managed Care Plan