

**Contract**

**Between**

**United States Department of Health and Human Services**

**Centers for Medicare & Medicaid Services**

**In Partnership with the**

**South Carolina**

**Department of Health and Human Services**

**and**

**<Entity>**

**Issued:**

**September 5, 2014**

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This Contract, made on September 5, 2014, is between the United States Department of Health and Human Services, acting by and through the Centers for Medicare & Medicaid Services (CMS), the State of South Carolina, acting by and through the South Carolina Department of Health and Human Services (SCDHHS), and <Entity> (the Coordinated and Integrated Care Organization (CICO)). The CICO's principal place of business is <Address>.

**WHEREAS**, CMS is an agency of the United States, Department of Health and Human Services, responsible for the administration of the Medicare, Medicaid, and State Children's Health Insurance Programs under Title XVIII, Title XIX, Title XI, and Title XXI of the Social Security Act;

**WHEREAS**, Section 1115A of the Social Security Act provides CMS the authority to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals under such titles, including allowing states to test and evaluate fully integrating care for dual eligible individuals in the State;

**WHEREAS**, SCDHHS is an agency responsible for operating a program of medical assistance under 42 U.S.C. § 1396 et seq., and the South Carolina State Plan for Medical Assistance (State Plan) and approved waivers under 1915 (c) authority under Title XIX of the Social Security Act, designed to pay for medical, behavioral health, and long term services and supports (LTSS) for an eligible Enrollee or Enrollees;

**WHEREAS**, the CICO is in the business of providing medical services, and CMS and SCDHHS desire to purchase such services from the CICO;

**WHEREAS**, the CICO agrees to furnish these services in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations;

**NOW, THEREFORE**, in consideration of the mutual promises set forth in this Contract, the Parties agree as follows:

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## Section 1. Definition of Terms

- 1.1. **Abuse** - (i) A manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs, generally used in conjunction with Fraud; or (ii) the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R. § 488.301), generally used in conjunction with neglect and/or exploitation.
- 1.2. **Advance Notice** – The notice the CICO must provide the member prior to forwarding an involuntary disenrollment request to the State, describing the behavior it has identified as disruptive and how it has impacted the CICO’s ability to arrange for or provide services to the member or to other members of the plan. As explained in the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, the notice must explain that his/her continued behavior may result in involuntary disenrollment and that cessation of the undesirable behavior may prevent this action. The CICO must include a copy of this notice and the date it was provided to the member in any information forwarded to CMS and the State. If the disruptive behavior ceases after the member receives notice and then later resumes, the CICO must begin the process again. This includes sending another advance notice.
- 1.3. **Adverse Action** - (i) The denial or limited authorization of a service authorization request, including the type or level of service; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the failure to provide services in a timely manner; or denial in whole or in part of a payment for a covered service for Enrollee; (iv) the failure by the CICO to render a decision within the required timeframes; or (v) solely with respect to a CICO that is the only CICO serving a rural area, the denial of an Enrollee’s request to obtain services outside of the Contracting Area.
- 1.4. **Alternative Format** – Provision of Enrollee information in a format that takes into consideration the special needs of those who, for example, are visually impaired or have limited reading proficiency. Examples of Alternative Formats shall include, but not be limited to, Braille, large font, audio tape, video tape, and enrollment information read aloud to Enrollee.
- 1.5. **Appeal** — Enrollee’s request for review of an Adverse Action of the CICO in accordance with Section 2.11 of the Contract.
- 1.6. **Behavioral Health Inpatient Services** – Services provided in a hospital setting to include inpatient medical/surgical/psychiatric services.
- 1.7. **Behavioral Health Outpatient Services** – Services that are provided in the home or community setting and to Enrollees who are able to return home after care without an overnight stay in a hospital or other inpatient facility.

- 1.8. **Behavioral Health & Substance Abuse Treatment Services-** Inpatient, outpatient and community mental health and rehabilitative services that are covered by the Demonstration.
- 1.9. **Benchmark Review-** Review conducted by SCDHHS and its EQRO to determine a CICO's readiness to proceed to the next transition phase of HCBS authority.
- 1.10. **Capitated Financial Alignment Model ("the Demonstration")** — A model where a State, CMS, and a health plan enter into a three-way contract, and the health plan receives a prospective blended payment to provide comprehensive, integrated, and coordinated care.
- 1.11. **Capitation Payment** – A payment CMS and SCDHHS make periodically to a CICO on behalf of each Enrollee enrolled under a Contract for the provision of services within this Demonstration, regardless of whether the Enrollees receives services during the period covered by the payment. Any and all costs incurred by the CICO in excess of a capitation payment shall be born in full by the CICO.
- 1.12. **Capitation Rate** — The sum of the monthly capitation payments for Demonstration Year 1 (reflecting coverage of Medicare Parts A & B services, Medicare Part D services, and Medicaid services, pursuant to Appendix A of this Contract) including: 1) the application of risk adjustment methodologies as described in Section 4.2.4 and 2) any payment adjustments as a result of the reconciliation described in Section 4.6. Total Capitation Rate revenue will be calculated as if all CICOs had received the full quality withhold payment.
- 1.13. **Care Call** – SCDHHS's automated system used for service documentation, service monitoring, web-based reporting, and billing to MMIS. For documentation of personal care services provided in an Enrollee's home, workers call a toll-free number upon starting and ending services. For other in home services and services not provided in an Enrollee's home, Providers call a toll-free number to document service delivery or document service delivery on the Internet. In all cases, services documented are compared with the prior authorization to determine if the service was provided appropriately. For monitoring of service delivery and reporting, real time reports allow Providers and Care Coordinators to monitor Enrollees more closely to ensure receipt of services. On a weekly basis, Care Call generates electronic billing to MMIS for services provided. Only authorized services and the total units provided (up to the maximum authorization) are submitted to MMIS for payment. This billing ensures accuracy of claim processing. Care Call is operated by a contracted vendor through a state and CMS approved procurement. For the purposes of the Demonstration, this system will be modified to bill each CICO directly for Demonstration related claims. SCDHHS will not process any Demonstration related claims.

- 1.14. **Care Coordinator** - An appropriately qualified professional who is the CICO's designated accountable point of contact for each Enrollee receiving Care Management services. The Care Coordinator is responsible for assisting Enrollees in directing and delegating Care Management duties, as needed, and may include the following: facilitating assessment of needs; developing, implementing and monitoring the care plan; and serving as the lead of the Multidisciplinary Team.
- 1.15. **Care Management** – A collaborative, person-centered process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services (both Medicare and Medicaid) required to meet an Enrollee's needs across the continuum of care. It is characterized by advocacy, communication, and resource management to promote quality, cost effective, positive outcomes.
- 1.16. **Carved-Out Service(s)** - The subset of Medicaid and Medicare covered services for which the CICO will not be responsible under this Contract.
- 1.17. **Case Management** – Provides service counseling, support and assists participants in coping with changing needs and making decisions regarding long term care services. Case Management ensures continued access to appropriate and available services.
- 1.18. **Center for Disability Resources (CDR), University of South Carolina** – The contracted vendor that provides training and certification for attendant care and companion services for Enrollees in SCDHHS's home and community based waiver programs.
- 1.19. **Centers for Medicare & Medicaid Services (CMS)** — The federal agency under the US Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
- 1.20. **CICO**- See Coordinated and Integrated Care Organization.
- 1.21. **Claim** - An itemized statement of services rendered by health care Providers (such as hospitals, physicians, dentists, etc.), billed electronically on the CMS-1500 or UB-04.
- 1.22. **Clinical Care Coordinator** - A licensed Registered Nurse or other individual employed by the Primary Care Provider or the CICO to provide Clinical Care Management.
- 1.23. **Clinical Care Management**- A set of services provided by a Clinical Care Coordinator that comprise intensive monitoring, follow-up, and care coordination, clinical management of high-risk Enrollees.
- 1.24. **Community Choices Waiver** - SCDHHS's CMS-approved 1915(c) waiver that covers a range of community support services offered to Enrollees who are elderly or adults who have a disability that would otherwise require a nursing facility level of care.

- 1.25. **Community Long Term Care (CLTC)** – The division of SCDHHS that operates Home and Community-Based Service Waiver programs for persons eligible for nursing home care but who prefer to receive services in the community. CLTC staff conducts level of care assessments and determinations for both community-based and facility-based LTSS.
- 1.26. **Complaint** – A grievance.
- 1.27. **Compliance Officer** – CICO staff who must meet the requirements at 42 C.F.R. § 422.503(b)(4)(vi)(B).
- 1.28. **Comprehensive Assessment** - A uniform tool developed by the State that assesses an Enrollee’s medical, psychosocial, cognitive, and functional status in order to determine their medical, behavioral health, LTSS, and social needs.
- 1.29. **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** - Enrollee survey tool developed and maintained by the Agency for Healthcare Research and Quality to support and promote the assessment of consumers’ experiences with health care.
- 1.30. **Contract-** The participation agreement that CMS and SCDHHS have with a CICO, for the terms and conditions pursuant to which a CICO may participate in this Demonstration.
- 1.31. **Contract Management Team (CMT)** — A group of CMS and SCDHHS representatives responsible for overseeing the Contract management functions outlined in Section 2.2 of the Contract.
- 1.32. **Contract Operational Start Date** — The first date on which any Enrollment into the CICO’s Medicare-Medicaid Plan (MMP) is effective.
- 1.33. **Coordinated and Integrated Care Organization (CICO)** - An entity approved by CMS and SCDHHS that enters into a Contract with CMS and SCDHHS in accordance with and to meet the purposes specified in this Contract. CICOs must be licensed by the South Carolina Department of Insurance.
- 1.34. **Corrective Action** - Improvements to an organizational process, which are taken to eliminate causes of non-conformities or other undesirable situations; identification and elimination of the cause of a problem, thus preventing its recurrence.
- 1.35. **Cost Sharing** - Co-payments paid by the Enrollee in order to receive medical services.
- 1.36. **Covered Services** — The set of services to be offered by the CICO.

- 1.37. **Cultural Competence** - Understanding those values, beliefs, and needs that are associated with the Enrollees' age, gender identity, sexual orientation, and/or racial, ethnic, or religious backgrounds. Cultural Competence also includes a set of competencies, which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities. A competency based on the premise of respect for Enrollee and cultural differences, and an implementation of a trust-promoting method of inquiry and assistance.
- 1.38. **Daily Transaction Reply Report (DTRR)** - A daily file that identifies whether a beneficiary submission was accepted or rejected and provides additional information about MMP membership. To assure MMPs receive proper payment, the MMP's membership records must agree with those reported to and maintained by CMS. There are three types of records included in the DTRR:
- 1.38.1 **Reply Records** – indicate the types of CMS action taken on the transactions submitted by the MMP daily, if transactions were received and processed.
  - 1.38.2 **Maintenance Records** – indicates existing membership records were updated because CMS has initiated action to change or update.
  - 1.38.3 **Plan Submitted Transaction Records** – displays the transaction submitted by MMPs; does not show results, but allows Plans to view a transaction paired with its generated replies.
- 1.39. **Demonstration** - The program, administered by CMS and SCDHHS for providing integrated care to Medicare-Medicaid Enrollees that is the subject of this Contract.
- 1.40. **Disenrollment** – The process by which an Enrollee's participation in the Demonstration is terminated. Reasons for Disenrollment include death, loss of eligibility for the Demonstration, or choice not to participate in the Demonstration. Disenrollment at the direction of the Enrollee may also be referred to as "Opt-Out."
- 1.41. **Eligible Beneficiary** — An individual who is eligible to enroll in the Demonstration but has not yet done so. This includes individuals who are enrolled in Medicare Part A and B and are receiving full Medicaid benefits, have no other comprehensive private or public health coverage, and who meet all other Demonstration eligibility criteria. In other materials including the CFR, such an individual is sometimes referred to as a "potential enrollee."

- 1.42. **Emergency Medical Condition** - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) 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 or her unborn child) in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part;.
- 1.43. **Emergency Services** –Inpatient and outpatient services covered under this Contract that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee’s Emergency Medical Condition.
- 1.44. **Employer of Record** - A company or organization that is legally responsible for paying employees, including dealing with employee taxes, benefits, insurance, and payroll
- 1.45. **Encounter Data** - The record of an Enrollee receiving any item(s) or service(s) provided through Medicaid or Medicare under a prepaid, capitated, or any other risk basis payment methodology submitted to CMS and the SCDHHS. This record must incorporate HIPAA security, privacy, and transaction standards and be submitted in the ASC X12N 837 format or any successor format.
- 1.46. **Enrollee** — Any Eligible Beneficiary who is actually enrolled with a CICO under the Demonstration.
- 1.47. **Enrollee Communications** — Materials designed to communicate plan benefits, policies, processes and/or Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.
- 1.48. **Enrollee Services** - The set of services to be offered by the CICO.
- 1.49. **Enrollees with Special Health Care Needs** - Enrollees including, at a minimum, those who have or are at increased risk to have chronic physical, developmental, or behavioral health condition(s); require an amount or type of services beyond those typically required for Enrollees of similar age; and may receive these services from an array of public and/or private providers across health, education and social systems of care.
- 1.50. **Enrollment** - The processes by which an Eligible Beneficiary is enrolled into the CICO's MMP.
- 1.51. **Enrollment Vendor** - A contracted entity that provides Enrollment support, including, but not limited to, customer service and options counseling.
- 1.52. **Enrollee Medical Record** - Documentation containing medical history, including information relevant to maintaining and promoting each Enrollee’s general health and well-being, as well as any clinical information concerning illnesses and chronic medical conditions.



- 1.53. **Excluded Parties List System (EPLS)** - The General Services Administration (GSA) maintains the EPLS, which includes information regarding parties debarred, suspended, proposed for debarment, excluded, or otherwise disqualified from receiving Federal funds. All Federal agencies are required to send information to the EPLS on parties they have debarred or suspended as described above; OIG sends monthly updates of the List of Excluded Individuals and Entities (LEIE) to GSA for inclusion in the EPLS. The EPLS does not include any unique identifiers; it provides only the name and address of excluded entities. If EPLS users believe that they have identified an excluded entity, they should confirm the information with the Federal agency that made the exclusion.
- 1.54. **Expedited Appeal** –The accelerated process by which a CICO must respond to an appeal by an Enrollee if a denial of care decision by a CICO may jeopardize life, health or ability to attain, maintain or regain maximum function.
- 1.55. **External Appeal** – An Appeal, subsequent to the CICO Appeal decision, to SCDHHS Fair Hearing process for Medicaid-based adverse decisions or the Medicare process for Medicare-based adverse decisions.
- 1.56. **External Quality Review Organization (EQRO)** – An independent entity that contracts with SCDHHS and evaluates the access, timeliness, and quality of care delivered by CICOs to their Enrollees and will perform Benchmark Reviews under the Demonstration.
- 1.57. **Federally-Qualified Health Center (FQHC)** — An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d(a)(2)(C).
- 1.58. **First Tier, Downstream and Related Entity** — An individual or entity that enters into a written arrangement with the CICO, acceptable to CMS, to provide administrative or health care services of the CICO under this Contract.
- 1.59. **Fiscal Employer Agent** – An organization operating under Section 3504 of the IRS Code and IRS Revenue Procedure 70-6 and Notice 2003-70 that has a separate Federal Employer Identification Number used for the sole purpose of filing federal employment tax forms and payments on behalf of program Enrollees who are receiving consumer directed services. The Fiscal Employer Agent operates as a sub-contractor under the State’s Care Call system.
- 1.60. **Flesch Readability Formula** - The formula by which readability of documents is tested as set forth in Rudolf Flesch, The Art of Readable Writing (1949, as revised 1974).
- 1.61. **Flexible Benefits** – Benefits that CICOs may choose to offer outside of the required Covered Services. Flexible Benefits will not be considered in the development of the Capitation Rate. Flexible Benefits offered by CICOs are subject to the rules for Medicare supplemental benefits.

- 1.62. **Fraud** - Knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit. Includes any act that constitutes fraud under federal or state law.
- 1.63. **Grievance** - Any Complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566, expressing dissatisfaction with any aspect of the CICO's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Primary Care Provider or employee of the CICO, or failure to respect the Enrollee's rights, as provided for in 42 C.F.R. § 438.400.
- 1.64. **Health Outcomes Survey (HOS)** — Enrollee survey used by CMS to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health.
- 1.65. **Healthcare Effectiveness Data and Information Set (HEDIS)** — Tool developed and maintained by the National Committee for Quality Assurance that is used by health plans to measure performance on dimensions of care and service in order to maintain and/or improve quality.
- 1.66. **Health Plan Management System (HPMS)** — A system that supports Contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.
- 1.67. **HIV/AIDS Waiver** – SCDHHS's CMS-approved 1915(c) waiver that covers a range of community support and medical services offered to eligible individuals diagnosed with HIV/AIDS and at risk of hospitalization.
- 1.68. **Home Again** - SCDHHS's CMS-approved Money Follows the Person (MFP) demonstration project designed to create a system of LTSS that better enable eligible individuals to transition from certain long-term care institutions into the community. Enrollees in the Demonstration may also qualify for services through Home Again.
- 1.69. **Home and Community-Based Services (HCBS) Waiver** – A variety of Medicaid home and community-based services as authorized under a §1915(c) waiver designed to offer an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid institutionalization (nursing facility) placement.
- 1.70. **Independent Living Philosophy** - The right of individuals with disabilities to control and direct their own lives and to participate actively in society.

- 1.71. **Indian Enrollee** – An Enrollee who is an Indian (as defined in Section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. §1603(c)).
- 1.72. **Individualized Care Plan (ICP)** – An integrated, individualized, person-centered plan developed by the Enrollee and his or her CICOs’ Multidisciplinary Team that addresses clinical and non-clinical needs identified in the Comprehensive Assessment and includes goals, interventions and expected outcomes.
- 1.73. **Initial Health Screen** - The initial evaluation of an Enrollee, which includes, but is not limited to, medical, physiological and psychological components.
- 1.74. **Involuntary Disenrollment** – Optional (discretionary) or required disenrollments according to Sections 40.2 and 40.3 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.
- 1.75. **List of Excluded Individuals and Entities (LEIE)** - When the Office of Inspector General (OIG) excludes a provider from participation in federally funded health care programs; it enters information about the provider into the LEIE, a database that houses information about all excluded providers. This information includes the provider’s name, address, provider type, and the basis of the exclusion. The LEIE is available to search or download on the OIG Web site and is updated monthly. To protect sensitive information, the downloadable information does not include unique identifiers such as Social Security numbers (SSN), Employer Identification numbers (EIN), or National Provider Identifiers (NPI).
- 1.76. **Long Term Care Assessment (LTC Assessment)** - A multifunctional tool that collects data about seniors and individuals seeking long term care services and is performed by SCDHHS for persons accessing nursing facility or HCBS waiver services. Evaluates their medical, behavioral, cognitive and functional capabilities and activities of daily living (such as eating, bathing, dressing, toileting, transferring and maintaining continence). The assessment’s functions include eligibility determination for programs and services, service plan development and establishing a service budget.
- 1.77. **Long Term Services and Supports (LTSS)** - A variety of services and supports that help elderly individuals and/or individuals with disabilities meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.
- 1.78. **Marketing, Outreach, and Enrollee Communications** — Any informational materials targeted to Enrollees that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260.

- 1.79. **Mechanical Ventilation Waiver** –SCDHHS’s CMS-approved 1915(c) waiver that covers a range of community support and medical services for eligible individuals who require a skilled or intermediate level of care and are dependent on mechanical ventilation for a minimum of six (6) hours per day.
- 1.80. **Medicaid** - The program of medical assistance benefits under Title XIX of the Social Security Act, Title 44 of the SC Code of Laws, applicable laws and regulations and various Demonstrations and Waivers thereof.
- 1.81. **Medicaid Management Information System (MMIS)** - The medical assistance and payment information system of SCDHHS.
- 1.82. **Medicaid Waiver** - Generally, a waiver of existing law authorized under Section 1115(a), 1115A, or 1915 of the Social Security Act and approved by CMS for operation for a specified period of time.
- 1.83. **Medical Home** - A medical home is a health care setting that incorporates a physician and provides care services in a high-quality and cost-effective manner. Care is facilitated by registries, information technology, health information exchange and other means to assure that patients receive the indicated care in an appropriate manner. The approach seeks to strengthen the patient-provider relationship by coordinating all care, including acute, chronic, preventative and end-of-life. Medical homes provide care that is accessible, continuous, comprehensive, patient-centered, coordinated, compassionate, and culturally and linguistically effective.
- 1.84. **Medically Necessary or Medical Necessity** - Services must be provided in a way that provides all protections to the Enrollee provided by Medicare and SC Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. §1395y. In accordance with Medicaid law and regulations, and per SC Medicaid, services must be 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 SC Medicaid member; (b) are provided at an appropriate facility or by an appropriate contracted provider and at the appropriate level of care for the treatment of the SC Medicaid member's medical condition; and, (c) are provided in accordance with generally accepted standards of medical practice.

- 1.85. **Medicare** — Title XVIII of the Social Security Act, the federal health insurance program for people age 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis. Medicare Part A provides coverage of inpatient hospital services and services of other institutional providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.
- 1.86. **Medicare Advantage** — The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 C.F.R. § 422 and provided by CMS-contracted health care plans.
- 1.87. **Medicare Waiver** - Generally, a waiver of existing law authorized under Section 1115A of the Social Security Act.
- 1.88. **Medicare-Medicaid Coordination Office** — Formally the Federal Coordinated Health Care Office, established by Section 2602 of the Affordable Care Act.
- 1.89. **Medicare-Medicaid Enrollees** - For the purposes of this Demonstration, individuals who are entitled to Medicare Part A and enrolled in Medicare Parts B and D and receive full benefits under the South Carolina Medicaid State Plan, and otherwise meet eligibility criteria for the Demonstration. See also Enrollee.
- 1.90. **Medicare-Medicaid Plan (MMP)** –The general term for plans contracted with CMS and South Carolina to participate in the Financial Alignment Demonstration. In South Carolina, these plans are referred to as Coordinated and Integrated Care Organizations (CICOs).
- 1.91. **Minimum Data Set (MDS)** — Part of the federally-mandated process for assessing individuals receiving care in Medicare and/or Medicaid certified skilled nursing facilities in order to record their overall health status regardless of payer source. The process provides a Comprehensive Assessment of individuals' current health conditions, treatments, abilities, and plans for discharge. The MDS is administered to all residents upon admission, quarterly, yearly, and whenever there is a significant change in an individual's condition. Section Q is the part of the MDS designed to explore meaningful opportunities for nursing facility residents to return to community settings.

- 1.92. **Multidisciplinary Team (MT)** - A team of professionals that collaborate, either in person or through other means, with Enrollees to develop, implement and periodically review an ICP that meets their medical, behavioral, LTSS, and social needs. MTs may include physicians, physician assistants, long term care providers, nurses, specialists, pharmacists, behavioral health specialists, and/or social workers appropriate for Enrollees' medical diagnoses and health condition, co-morbidities, and community support needs. MTs employ both medical and social models of care.
- 1.93. **National Committee for Quality Assurance (NCQA)** – An independent 501 (c)(3) nonprofit organization in the United States designed to improve healthcare quality.
- 1.94. **Network Provider** – An entity that provides healthcare services to Enrollees and is under contract with the CICO.
- 1.95. **Office of Inspector General List of Excluded Individuals/Entities (LEIE)** – Provides information to the health care industry, patients and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid and all other Federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE.
- 1.96. **(Demonstration) Ombudsman** - The independent entity that will provide advocacy and problem resolution support for Enrollees, and serve as an early and consistent means of identifying systemic problems with the Demonstration.
- 1.97. **Opt-Out** – A process by which an Enrollee can choose not to participate in the Demonstration.
- 1.98. **Out-of-Network Coverage** - Coverage provided outside of the established CICO network; medical care rendered to an Enrollee by a provider not affiliated or sub-contracted with the CICO.
- 1.99. **Passive Enrollment** — An Enrollment process through which an Eligible Beneficiary is enrolled by SCDHHS (or its vendor) into a CICO's MMP, following a minimum sixty (60) day advance notification that includes the plan selection and the opportunity to select a different plan, make another Enrollment decision, or decline Enrollment into a CICO, or Opt-Out of the Demonstration prior to the effective date.
- 1.100. **Patient Liability** – The amount an Enrollee must contribute toward the cost of nursing facility services. Patient liability is required to be calculated for every Enrollee receiving nursing facility services, although not every eligible Enrollee will contribute this amount each month.

- 1.101. **Phoenix** – SCDHHS’s automated Case Management system which maintains records of a number of critical functions, including all intake, assessment, and care planning activities. Key features of Phoenix include sections for a home assessment, caregiver supports, and quality indicators. There are also edits to ensure compliance with federal regulations (e.g., waiver admission is within thirty (30) days of the most recent level of care determination) as well as state policies. The system also includes a method to identify waiver participants most at risk for missed in-home visits and those most at risk in the event of natural disasters. Phoenix functionality will be expanded for use in the Demonstration, and CICOs will be required to utilize it for specified Demonstration activities.
- 1.102. **Post-stabilization Care Services** - Covered services related to the Enrollee's underlying condition that are provided after the Enrollee's Emergency Medical Condition has been Stabilized and/or under the circumstances described in 42 C.F.R. § 438.114(e) to improve or resolve the Enrollee's condition.
- 1.103. **Pre-Admission Screening (PAS)** - The process to: (i) evaluate the functional, nursing, and social supports of Enrollees referred for LTSS; (ii) assist Enrollees in determining needed services; (iii) evaluate whether community services are available to meet the Enrollees’ needs; and (iv) refer Enrollees to the appropriate provider for Medicaid-funded facility or home- and community-based care.
- 1.104. **Prevalent Languages** —When five (5) percent of the CICO’s enrolled population is non-English speaking and speaks Spanish or another common language other than English.
- 1.105. **Privacy or Privacy Rules** - Requirements established in the Privacy Act of 1974, Health Insurance Portability and Accountability Act of 1996, and implementing regulations, Medicaid regulations, including 42 C.F.R. §§ 431.300 - 431.307, as well as relevant South Carolina privacy laws.
- 1.106. **Program of All-Inclusive Care for the Elderly (PACE)** — A capitated benefit for frail elderly authorized by the Balanced Budget Act 1997 (BBA) and provided under the State Medicaid Plan that features a comprehensive service delivery system an integrated Medicare and Medicaid financing. PACE is a three-way partnership between the federal government, South Carolina, and the PACE organization.
- 1.107. **Project Manager** – Employed by the CICO and responsible for managing and coordinating the resources allocated for Healthy Connections Prime. The project manager ensures the CICO’s compliance with the parameters of the program including program deliverables. The project manager is empowered to represent the Contract in all matters pertaining Healthy Connections Prime.
- 1.108. **Provider(s)** – A person or body of individuals who assists in identifying, preventing or treating illness or disability.

- 1.109. **Provider Appeal (Medicaid Only)** - An Appeal to a CICO filed by a service Provider that has already provided a service and has received a denial, in whole or part, regarding payment or authorization for the service. The Provider must utilize the CICO's internal process for Providers for filing an Appeal. In addition, a Provider, with written authorization from an Enrollee, may also file an Appeal with SCDHHS on behalf of an Enrollee for a Medicaid-based service that the Provider has not yet rendered. A Provider must exhaust the CICO's internal Appeal process for Enrollees as a prerequisite to filing an Appeal to SCDHHS.
- 1.110. **Provider Contract** - An agreement between a CICO and a Provider which describes the conditions under which the Provider agrees to furnish covered services to Enrollees under this Contract. All Provider contract templates for Medicaid-funded services between the CICO and a Provider must be approved by SCDHHS.
- 1.111. **Provider Network** – A network of health care and social support Providers, including, but not limited to, primary care physicians, nurses, nurse practitioners, physician assistants, care managers, specialty Providers, behavioral health/substance abuse Providers, community and institutional long term care Providers, pharmacy Providers, and acute Providers employed by or under subcontract with the CICO.
- 1.112. **Provider Preventable Condition** - A hospital acquired condition or a condition occurring in any health care setting that has been found by SCDHHS, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines, has a negative consequence for the Enrollee, and is auditable.
- 1.113. **Public Partnership Limited (PPL)** – SCDHHS's Fiscal Employer Agent contractor for self-directed attendant care services.
- 1.114. **Quality Improvement Organization (QIO)** – As set forth in Section 1152 of the Social Security Act and 42 C.F.R. Part 476, an organization under contract with CMS to perform utilization and quality control peer review in the Medicare program or an organization designated as QIO-like by CMS. The QIO or QIO-like entity provides quality assurance and utilization review.
- 1.115. **Quality Improvement Strategic Work Plan** - A quality improvement plan designed to achieve measurable improvement in processes and outcomes of care. Improvements are achieved through interventions that target Network Providers, the CICO, and/or Enrollees.



- 1.116. **Readiness Review** - Prior to the operational start date of the three-way contract with SCDHHS and CMS, the CICO will undergo a Readiness Review. The Readiness Review will evaluate each CICO's ability to comply with the Demonstration requirements, including, but not limited to, the ability to quickly and accurately process claims and Enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare- and Medicaid-covered Medically Necessary services. CMS and SCDHHS will use the results to inform their decision of whether the CICO is ready to participate in the Demonstration. At a minimum, each Readiness Review will include a desk review and a site visit to the CICO's headquarters.
- 1.117. **Serious Reportable Events (SREs)** - This is an incident involving death or serious harm to a patient resulting from a lapse or error in a healthcare facility. SREs are commonly referred to as "never events."
- 1.118. **Service Area** - The specific geographic area of South Carolina designated in the CMS HPMS, and as referenced in Appendix J, for which the CICO agrees to provide Covered Services to all Enrollees who select or are passively enrolled with the CICO.
- 1.119. **Signs and Symptoms Questionnaire** – A tool used to define an Enrollee's current tuberculosis status, utilized in order to identify tuberculosis risk factors in healthcare Providers.
- 1.120. **South Carolina Certified Nurse Aide (CNA) Registry** – A web-based registry maintained by a SCDHHS contractor that lists certified nurse aides and is in compliance with provisions in the Omnibus Budget Reconciliation Act (OBRA) of 1987.
- 1.121. **South Carolina Law Enforcement Division (SLED)** – The agency that provides quality manpower and technical assistance to law enforcement agencies and conducts investigations on behalf of the State as directed by the Governor and Attorney General.
- 1.122. **Solvency** - Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by SCDHHS and agreed to by CMS.
- 1.123. **South Carolina Department of Disabilities and Special Needs (SCDDSN)** - SCDDSN is the state agency that plans, develops, oversees and funds services for South Carolinians with severe, lifelong disabilities of intellectual disability, autism, traumatic brain injury and spinal cord injury and conditions related to each of these four disabilities.
- 1.124. **South Carolina Department of Health and Human Services** - The South Carolina Department of Health and Human Services (SCDHHS) is designated as the single state agency for the administration of the Medicaid program in South Carolina. Organizationally, SCDHHS is a cabinet-level agency under the Governor of the State of South Carolina.

- 1.125. **South Carolina Department of Insurance** - The State of South Carolina Department of Insurance oversees the insurance marketplace in South Carolina, by ensuring the solvency of insurers; by enforcing and implementing the insurance laws of this State; and by regulating the insurance industry. Organizationally, SCDHHS is a cabinet-level agency under the Governor of the State of South Carolina.
- 1.126. **Stabilized** - As defined in 42 C.F.R. § 489.24(b), means, with respect to an Emergency Medical Condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer (including discharge) of the Enrollee from a hospital or, in the case of a pregnant woman who is having contractions, that the woman has delivered the child and the placenta.
- 1.127. **State Fair Hearing** – A hearing to review those decisions whenever a claim for benefits is denied or not acted upon with reasonable promptness. This includes any action, or inaction, that affects either the Enrollee’s eligibility to be enrolled in Medicaid or the person’s receipt of a particular medical service covered by the Demonstration.
- 1.128. **Urgent Care** — Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician’s office, or in a hospital emergency department if a clinic or physician’s office is inaccessible. Urgent Care does not include primary care services or services provided to treat an Emergency Medical Condition.
- 1.129. **Utilization Management (UM)** - The process of evaluating the necessity, appropriateness and efficiency of health care services against established guidelines and criteria.
- 1.130. **Waiver Case Manager** - Waiver Case Managers are employees of contracted Medicaid Case Management Providers. These Case Management Providers must be conflict free and cannot provide any other services that could be incorporated in the Waiver Service Plan. This includes services such as personal care and adult day care that these case managers authorize. It also includes other long term care services that waiver Enrollees might receive, such as hospice and home health services.
- 1.131. **Waiver Service Plan** – Outlines and delineates the Enrollee’s home and community based services. The Waiver Service Plan reflects needs and goals identified during the Long Term Care Level of Care Assessment. It must be incorporated into the Enrollee’s ICP to assure integration of HCBS Waiver services.

## Section 2. CICO Responsibilities

### 2.1. Compliance

#### 2.1.1. CICO Requirements for State Operations

2.1.1.1. Through the Capitated Financial Alignment Model initiative, CMS and SCDHHS will work in partnership to offer Eligible Beneficiaries the option of enrolling in a CICO, which consists of a comprehensive network of health and social service Providers. The CICO will deliver and coordinate all components of Medicare and SCDHHS Covered Services for Enrollees.

#### 2.1.1.2. Licensure

2.1.1.2.1. The CICO shall obtain and retain at all times during the period of this Contract a valid license issued with the South Carolina Department of Insurance (SCDOI) and comply with all terms and conditions set forth in S.C. Code Ann. § 38-33-10 *et seq.*, 25A S.C. Code Ann. Regs. 69-22, and any and all other applicable laws of the State of South Carolina, as amended.

#### 2.1.1.3. Certification

2.1.1.3.1. In order to operate as a CICO, all managed care health insurance plan licensees must obtain Service Area approval certification from SCDHHS and remain certified by the SCDOI.

#### 2.1.1.4. Accreditation

2.1.1.4.1. The CICO must adhere to managed care standards at 42 C.F.R § 438.214 and 42 C.F.R. § 422.204 and must be health plan accredited by the National Committee for Quality Assurance (NCQA) and follow NCQA procedural requirements for standards for credentialing and re-credentialing. CICOs that are not NCQA accredited must pursue an “Interim Evaluation” status by December 2014.

2.1.1.4.2. The CICO must report to SCDHHS any deficiencies noted by the NCQA for the CICO’s Medicare and/or Medicaid product lines within thirty (30) calendar days of being notified of the deficiencies, or on the earliest date permitted by NCQA, whichever is earliest.

2.1.1.5. Mergers and Acquisition

2.1.1.5.1. In addition to the requirements at 42 C.F.R. § 422 Subpart L, the CICO must adhere to the NCQA notification requirements with regards to mergers and acquisitions and must notify SCDHHS and CMS of any action by NCQA that is prompted by a merger or acquisition (including, but not limited to change in accreditation status, loss of accreditation, etc.).

2.1.2. Compliance with Contract Provisions and Applicable Laws

2.1.2.1. The CICO must, to the satisfaction of CMS and SCDHHS:

2.1.2.1.1. Comply with all provisions set forth in this Contract;

2.1.2.1.2. Comply with all applicable provisions of federal and state laws, regulations, guidance, waivers, Demonstration terms and conditions, including the implementation of a compliance plan. The CICO must comply with the Medicare Advantage and Prescription Drug Plan requirements in Part C and D of Title XVIII, and 42 C.F.R. Part 422 and Part 423, except to the extent that waivers from these requirements are provided in the Memorandum of Understanding (MOU) signed by CMS and SCDHHS for this initiative; and

2.1.2.1.3. Comply with other laws.

2.1.2.1.3.1. No obligation imposed herein on the CICO shall relieve the CICO of any other obligation imposed by law or regulation, including, but not limited to the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by SCDHHS or CMS.

2.1.2.1.3.2. SCDHHS and CMS shall report to the appropriate agency any information it receives that indicates a violation of a law or regulation.

2.1.2.1.3.3. SCDHHS or CMS will inform the CICO of any such report unless the appropriate agency to which SCDHHS or CMS has reported requests that SCDHHS or CMS not inform the CICO.

2.1.2.1.4. Adopt and implement an effective compliance program that aligns with the approved South Carolina Medicaid managed care requirements to prevent, detect and correct Fraud, waste, and Abuse. In addition, the compliance program must, at a minimum, include written policies, procedures, and standards of conduct that:

2.1.2.1.4.1. Articulate the CICO's commitment to comply with all applicable federal and state standards, including, but not limited to:

2.1.2.1.4.1.1. Fraud detection and investigation;

2.1.2.1.4.1.2. Procedures to guard against Fraud and Abuse;

2.1.2.1.4.1.3. Prohibitions on certain relationships as required by 42 C.F.R. § 438.610;

2.1.2.1.4.1.4. Obligation to suspend payments to Providers;

2.1.2.1.4.1.5. Disclosure of ownership and control of CICO;

2.1.2.1.4.1.6. Disclosure of business transactions;

2.1.2.1.4.1.7. Disclosure of information on persons convicted of health care crimes,

2.1.2.1.4.1.8. Reporting adverse actions taken for Fraud, integrity, and quality; and

2.1.2.1.4.1.9. Appointment of a Medicare Compliance Officer who acts as the compliance program point of contact for both internal staff and CMS representatives.

2.1.2.1.4.2. Describe compliance expectations as embodied in the CICO's standards of conduct;

2.1.2.1.4.3. Implement the operation of the compliance program;

2.1.2.1.4.4. Provide guidance to employees and others on addressing potential compliance issues;

- 2.1.2.1.4.5. Identify how to communicate compliance issues to appropriate compliance personnel;
- 2.1.2.1.4.6. Describe how potential compliance issues are investigated and resolved by the CICO; and
- 2.1.2.1.4.7. Include a policy of non-intimidation and non-retaliation for good faith participation in the compliance program, including, but not limited to, reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials.
- 2.1.2.1.5. Develop and implement an effective compliance program that applies to its operations, consistent with 42 C.F.R. § 420, et seq, 42 C.F.R. § 422.503, 42 C.F.R. § 423.504, and 42 C.F.R. §§ 438.600-610, 42 C.F.R. § 455.
- 2.1.2.1.6. Comply with all aspects of the joint Readiness Review.

## 2.2. Contract Management and Readiness Review Requirements

### 2.2.1. Contract Readiness Review Requirements

- 2.2.1.1. CMS and SCDHHS, or their designee, will conduct a Readiness Review of each CICO, which must be completed successfully, as determined by CMS and SCDHHS, prior to the Contract Operational Start Date.
- 2.2.1.2. CMS and SCDHHS Readiness Review Responsibilities
  - 2.2.1.2.1. CMS and SCDHHS or its designee will conduct a Readiness Review of each CICO that will include, at a minimum, one on-site review. This review shall be conducted prior to marketing to and Enrollment of Eligible Beneficiaries into the CICO's plan. CMS and SCDHHS or its designee will conduct the Readiness Review to verify the CICO's assurances that the CICO is ready and able to meet its obligations under the Contract.
  - 2.2.1.2.2. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

- 2.2.1.2.2.1. Network Provider composition and access, in accordance with Section 2.6.9.7;
- 2.2.1.2.2.2. Staffing, including key personnel and functions directly impacting Enrollees (e.g., adequacy of Enrollee Services staffing, in accordance with Section 2.2.3);
- 2.2.1.2.2.3. Capabilities of First Tier, Downstream and Related Entities, in accordance with Appendix E;
- 2.2.1.2.2.4. Care Management capabilities, in accordance with Section 2.5;
- 2.2.1.2.2.5. Enrollee Services capability (materials, processes and infrastructure, e.g., call center capabilities), in accordance with Section 2.9;
- 2.2.1.2.2.6. Comprehensiveness of quality management/quality improvement and Utilization Management (UM) strategies, in accordance with Section 2.12;
- 2.2.1.2.2.7. Internal Grievance and Appeal policies and procedures, in accordance with Section 2.10; Section 2.11;
- 2.2.1.2.2.8. Fraud and Abuse and program integrity policies and procedures, in accordance with Section 2.1.2.1.4;
- 2.2.1.2.2.9. Financial solvency, in accordance with Section 2.14;
- 2.2.1.2.2.10. Information systems, including claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with Section 2.15.5, including information technology (IT) testing and security assurances.

2.2.1.2.3. No Eligible Beneficiary shall be enrolled into the CICO unless and until CMS and SCDHHS determine that the CICO is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

- 2.2.1.2.4. CMS and SCDHHS or their designee will identify to the CICO all areas where the CICO is not ready and able to meet its obligations under the Contract and provide an opportunity for the CICO to correct such areas to remedy all deficiencies prior to the Contract Operational Start Date.
- 2.2.1.2.5. CMS or SCDHHS may, at its discretion, postpone the Contract Operational Start Date for the CICO that fails to satisfy all Readiness Review requirements. If, for any reason, the CICO does not fully satisfy CMS or SCDHHS that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, and CMS or SCDHHS do not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then CMS or SCDHHS may terminate the Contract pursuant to Section 5.5 of this Contract.

#### 2.2.1.3. CICO Readiness Review Responsibilities

- 2.2.1.3.1. Demonstrate to CMS and SCDHHS's satisfaction that the CICO is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the CICO engaging in marketing of its Demonstration product;
- 2.2.1.3.2. Provide CMS and SCDHHS, or their designee, with corrections requested by the Readiness Review.

#### 2.2.2. Contract Management

- 2.2.2.1. The CICO shall employ a qualified individual to serve as the Project Manager of its Capitated Financial Alignment model. The Project Manager may be the same as the Compliance Officer as required by 42 C.F.R. § 422.503; if the CICO assigns separate individuals to the Compliance Officer and Project Manager roles, these individuals should work together to ensure continuity of CICO operations. The Project Manager shall be located in an operations/business office within the State of South Carolina. The Project Manager shall be dedicated to the CICO's program and be authorized and empowered to represent the CICO in all matters pertaining to the CICO's program, such as rate negotiations for the CICO program, claims payment, and Provider relations/contracting. The Project Manager shall be able to



make decisions about the program and policy issues. The Project Manager and/or Compliance Officer shall act as liaison between the CICO, CMS, and SCDHHS, and has responsibilities that include but, are not limited to, the following:

- 2.2.2.1.1. Ensure the CICO's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;
- 2.2.2.1.2. Oversee all activities by the CICO and its First Tier, Downstream and Related Entities, including, but not limited to coordinating with the CICO's quality management director, medical director, and behavioral health clinician;
- 2.2.2.1.3. Ensure that Enrollees receive written notice of any significant change in the manner in which services are rendered to Enrollees at least thirty (30) days before the intended effective date of the change, such as a retail pharmacy chain leaving the Provider Network;
- 2.2.2.1.4. Receive and respond to all inquiries and requests made by CMS and SCDHHS in timeframes and formats specified by CMS and SCDHHS;
- 2.2.2.1.5. Meet with representatives of CMS or SCDHHS, or both, on a periodic or as-needed basis to resolve issues within specified timeframes;
- 2.2.2.1.6. Ensure the availability to CMS and SCDHHS, upon their request, of those Enrollees of the CICO's staff who have appropriate expertise in administration, operations, finance, management information systems, claims processing and payment, clinical service provision, quality management, Enrollee services, UM, Provider Network management, and benefit coordination;
- 2.2.2.1.7. Represent the CICO at the SCDHHS and CMS meetings;
- 2.2.2.1.8. Coordinate requests and activities among the CICO, all First Tier, Downstream, and Related Entities, CMS, and SCDHHS;

- 2.2.2.1.9. Make best efforts to promptly resolve any issues related to the Contract identified either by the CICO, CMS, or SCDHHS; and
- 2.2.2.1.10. Meet with CMS and SCDHHS at the time and place requested by CMS and the SCDHHS if either CMS or SCDHHS or both, determine that the CICO is not in compliance with the requirements of the Contract.

### 2.2.3. Organizational Structure

- 2.2.3.1. The CICO shall establish and maintain the interdepartmental structures and processes to support the operation and management of its Demonstration line of business in a manner that fosters integration of physical health, behavioral health, and community-based and facility-based LTSS service provisions. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment, when such data is available. The CICO shall describe the interdepartmental structures and processes to support the operation and management of its Demonstration line of business.
- 2.2.3.2. On an annual basis, and on an ad hoc basis when changes occur or as directed by SCDHHS and CMS, the CICO shall submit to the CMT an overall organizational chart that includes senior and mid-level managers.
- 2.2.3.3. For all employees, by functional area, the CICO shall establish and maintain policies and procedures for managing staff retention and employee turnover. Such policies and procedures shall be provided to the CMT upon request.
- 2.2.3.4. If any Demonstration specific services and activities are provided by a First Tier, Downstream or Related Entity, the CICO shall submit the organizational chart of the First Tier, Downstream or Related Entity which clearly demonstrates the relationship with the First Tier, Downstream or Related Entity and the CICO's oversight of the First Tier, Downstream or Related Entity.
- 2.2.3.5. The CICO shall immediately notify the CMT whenever positions held by key personnel become vacant and shall notify the CMT when the position is filled and by whom. SCDHHS and CMS reserve the right to approve or reject rehires to key management level positions.
  - 2.2.3.5.1. Key personnel positions include, but are not limited to:

- 2.2.3.5.1.1. The CICO's Project Manager and/or the Executive with oversight of the program,

- 2.2.3.5.1.2. CICO's chief executive officer, if applicable,
- 2.2.3.5.1.3. Chief financial officer,
- 2.2.3.5.1.4. Chief operating officer or director of operations,
- 2.2.3.5.1.5. Chief medical officer/medical director,
- 2.2.3.5.1.6. Pharmacy director,
- 2.2.3.5.1.7. Quality management coordinator,
- 2.2.3.5.1.8. UM coordinator,
- 2.2.3.5.1.9. Care coordination/Care Management/Disease Management Program manager,
- 2.2.3.5.1.10. Behavioral health clinical director,
- 2.2.3.5.1.11. Director of LTSS,
- 2.2.3.5.1.12. Community liaison,
- 2.2.3.5.1.13. Americans with Disabilities Act (ADA) compliance director and/or point of contact for reasonable accommodations,
- 2.2.3.5.1.14. Claims director,
- 2.2.3.5.1.15. Management information system (MIS) director,
- 2.2.3.5.1.16. IT director, and
- 2.2.3.5.1.17. Medicare compliance officer.

2.2.3.6. If SCDHHS or CMS is concerned that any of the key personnel are not performing the responsibilities including, but not limited to, those provided for in the person's position under this section (Section 2.2.3) SCDHHS shall inform the CICO of this concern. The CICO shall investigate said concerns promptly, take any actions the CICO reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify SCDHHS of such actions. If the CICO's actions fail to ensure full compliance with the terms of this Contract, as determined by SCDHHS, the Corrective Action Provisions in Section 5.3.13 may be invoked by SCDHHS and CMS.

#### 2.2.4. Enrollee Advisory Committee

2.2.4.1. The CICO shall establish an Enrollee advisory committee that will provide regular feedback to the CICO's governing board on issues of Demonstration management and Enrollee care. The CICO shall ensure that the Enrollee advisory committee:

2.2.4.1.1. Meets at least quarterly throughout the Demonstration beginning second quarter of CY 2015; and,

2.2.4.1.2. Is comprised of Enrollees, family members and other caregivers that reflect the diversity of the Demonstration population, including Enrollees with disabilities.

2.2.4.2. The CICO shall also include Ombudsman reports in quarterly updates to the Enrollee advisory committee and shall participate in all statewide stakeholder and oversight convenings as requested by SCDHHS and/or CMS.

### 2.3. Eligibility and Enrollment Responsibilities

#### 2.3.1. Eligibility Determinations

2.3.1.1. CMS and SCDHHS shall have sole responsibility for determining the eligibility of an Enrollee for Medicare- and Medicaid- funded services. CMS and SCDHHS shall have sole responsibility for determining Enrollment in the CICO.

#### 2.3.2. General Enrollment

2.3.2.1. SCDHHS will begin opt-in Enrollment prior to the initiation of Passive Enrollment. During this opt-in Enrollment period, Eligible Beneficiaries may choose to enroll into a particular CICO. Eligible Beneficiaries who do not select a CICO, or who do not Opt-Out of the Demonstration, will be assigned to a CICO during Passive Enrollment.

2.3.2.2. The first effective Enrollment date for this initial opt-in period is scheduled for no earlier than January 1, 2015.

2.3.2.3. Enrollment requests, including Enrollment requests to transfer from one CICO to a different CICO, received after the 12th of the month will be effective the first calendar day of the second month following initial receipt of the request.

2.3.2.4. A CICO that is sanctioned after the execution of a Contract will be unable to enroll any Eligible Beneficiaries – either through Passive Enrollment or opt-in Enrollment – until the sanction is lifted.

### 2.3.3. Passive Enrollment

2.3.3.1. SCDHHS may conduct Passive Enrollment during the term of the Contract to assign Eligible Beneficiaries who do not select a CICO, Opt-Out of the Demonstration, or are newly eligible.

2.3.3.1.1. For Wave I (Upstate Region as defined in Appendix J), Passive Enrollment to the CICO will begin no sooner than April 1, 2015. SCDHHS will provide notice of Passive Enrollments at least sixty (60) calendar days prior to the effective dates to Eligible Beneficiaries, and will accept Opt-Out requests prior to the effective date of Enrollment.

2.3.3.1.2. For Wave II (Coastal Region as defined in Appendix J), Passive Enrollment to the CICO will begin no sooner than June 1, 2015. SCDHHS will provide notice of Passive Enrollments at least sixty (60) days prior to the effective date to Eligible Beneficiaries, and will accept Opt-Out requests prior to the effective date of Enrollment.

2.3.3.1.3. For Wave III (HCBS Waiver population), Passive Enrollment to the CICO will begin no sooner than August 1, 2015. SCDHHS will provide notice of Passive Enrollments at least sixty (60) days prior to the effective dates to Eligible Beneficiaries, and will accept Opt-Out requests prior to the effective date of Enrollment.

2.3.3.1.4. SCDHHS will apply an intelligent assignment methodology to assign Eligible Beneficiaries to a CICO, which will include at minimum:

2.3.3.1.4.1. Existing Provider relationships including HCBS Waiver Providers;

2.3.3.1.4.2. Previous history with another product of the CICO (e.g., Medicare Advantage or Medicaid Managed Care Organization) within the previous twelve (12) months;

2.3.3.1.4.3. Household members currently assigned to a CICO; and

- 2.3.3.1.4.4. A balanced representation of high, medium and low risk Enrollees based on SCDHHS-defined parameters.
  - 2.3.3.1.5. CMS and SCDHHS may suspend and/or modify Passive Enrollment to a CICO if the CICO does not meet reporting requirements, as necessary to maintain Passive Enrollment as set forth by CMS and SCDHHS, including those regarding the quantitative data received related to Comprehensive Assessment completion rate, care transitions, and Grievances and Appeals.
- 2.3.3.2. Enrollment Transactions
- 2.3.3.2.1. Enrollments and disenrollments will be processed through SCDHHS or its authorized agent. SCDHHS or its authorized agent will then submit Passive Enrollment transactions sixty (60) calendar days in advance of the effective date, to the CMS Medicare Advantage Prescription Drug (MARx) Enrollment system directly or via a third-party CMS designates to receive such transactions, and SCDHHS or its authorized agent will receive notification on the next Daily Transaction Reply Report. The CICO will then receive Enrollment transactions from SCDHHS or its authorized agent. The CICO will also use the third-party CMS designates to submit additional Enrollment-related information to MARx, and receive files from CMS.
  - 2.3.3.2.2. The CICO must have a mechanism for receiving timely information about all Enrollments in the CICO's plan, including the effective Enrollment date, from CMS and SCDHHS systems.
  - 2.3.3.2.3. The CICO shall accept for Enrollment all Eligible Beneficiaries, as described in Section 3.2. The CICO shall accept for Enrollment all Eligible Beneficiaries identified by SCDHHS at any time without regard to income status, physical or mental condition, age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing conditions, expected health status, or need for health care services.

- 2.3.3.2.4. Upon instruction by SCDHHS, its authorized agent may not provide new Enrollments within six (6) months (or less) of the end date of the Demonstration, unless the Demonstration is renewed or extended.
- 2.3.3.2.5. SCDHHS and CMS will monitor Enrollments and Passive Enrollment auto-assignments to all CICOs and may make adjustments to the volume and spacing of Passive Enrollment periods based on the capacity of the CICO, and of CICOs in aggregate, to accept projected Passive Enrollments. Adjustments to the volume of Passive Enrollment based on the capacity of the CICO will be subject to any capacity determinations, including, but not limited to, those documented in the CMS and SCDHHS final Readiness Review report and ongoing monitoring by CMS and SCDHHS.

#### 2.3.4. Enrollee Materials

- 2.3.4.1. For Passive Enrollments, the CICO shall send the following materials thirty (30) calendar days prior to the Enrollee's effective date of coverage:
  - 2.3.4.1.1. A CICO-specific Summary of Benefits for those offered Passive Enrollment (this document is not required for opt-in Enrollments). Providing the Summary of Benefits, which is considered marketing material normally provided prior to the Eligible Beneficiary making an Enrollment request, ensures that those who are offered Passive Enrollment have a similar scope of information as those who voluntarily enroll.
  - 2.3.4.1.2. A comprehensive integrated formulary that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the CICO.
  - 2.3.4.1.3. A combined Provider and Pharmacy Directory that includes all providers of Medicare, Medicaid, and flexible benefits.
  - 2.3.4.1.4. Proof of health insurance coverage so that the Enrollee may begin using CICO services as of the effective date. This proof must include the 4Rx prescription drug data necessary to access benefits.

- 2.3.4.1.4.1. NOTE: This proof of coverage is not the same as the Evidence of Coverage document described in the state-specific Demonstration Marketing Guidelines. The proof of coverage may be in the form of an Enrollee ID card, the Enrollment form, and/or a notice to the Enrollee. As of the effective date of Enrollment, the CICO's systems should indicate active membership.
- 2.3.4.2. For Passive Enrollment, the CICO must send the following no later than the last calendar day of the month prior to the effective date of coverage:
  - 2.3.4.2.1. A single ID card for accessing all covered services under the CICO.
  - 2.3.4.2.2. An Enrollee Handbook (Evidence of Coverage) to ensure that the Enrollee has sufficient information about CICO benefits to make an informed decision prior to the Enrollment effective date.
- 2.3.4.3. For the individuals who opt into the Demonstration, the CICO shall provide the following materials no later than ten (10) calendar days from receipt of CMS confirmation of Enrollment or by the last calendar day of the month prior to the effective date, whichever occurs later:
  - 2.3.4.3.1. A comprehensive integrated formulary;
  - 2.3.4.3.2. A combined Provider and Pharmacy Directory;
  - 2.3.4.3.3. A single ID card;
  - 2.3.4.3.4. An Enrollee Handbook (Evidence of Coverage); and
  - 2.3.4.3.5. NOTE: For opt-in Enrollment requests received late in the month, see §30.4.2 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance (After the Effective Date of Coverage) for more information.
- 2.3.4.4. For all Enrollments, regardless of how the Enrollment request is made, the CICO must explain:



- 2.3.4.4.1. The charges for which the Eligible Beneficiary will be liable (e.g., coinsurance for Medicaid benefits in CICO, if applicable; LIS co-payments for Part D covered drugs), if this information is available at the time the acknowledgement notice is issued (confirmation notices and combination acknowledgement/confirmation notices must contain this information).
- 2.3.4.4.2. The Eligible Beneficiary authorization for the disclosure and exchange of necessary information between the CICO, SCDHHS, and CMS.
- 2.3.4.4.3. The requirements for use of the CICO's Network Providers. SCDHHS, or CICO as appropriate, must also obtain an acknowledgment by the Enrollee that he/she understands that care will be received through designated Providers except for Emergency Services and urgently needed care.
  - 2.3.4.4.3.1. For Passive Enrollment, if the individual does not decline Passive Enrollment, that is considered to be the required acknowledgement.
- 2.3.4.4.4. The effective date of coverage and how to obtain services prior to the receipt of an ID card (if the CICO has not yet provided the ID card).
- 2.3.4.5. After the Effective Date of Coverage
  - 2.3.4.5.1. CMS recognizes that in some instances the SCDHHS (or its authorized agent, if SCDHHS delegates any notifications to the authorized agent) will be unable to provide the materials and required notifications to new Enrollees prior to the effective date, as required in §30.4.1 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. . These cases will generally occur when an opt-in Enrollment request is received late in a month with an effective date as described in Section 2.3.2.3. In these cases, SCDHHS still must provide the Enrollee all materials described in §30.4.1 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance no later than ten (10) calendar days after receipt of the completed Enrollment request.

2.3.4.5.2. Additionally, the CICO is also strongly encouraged to call these new Enrollees as soon as possible (within one to three calendar days of receiving the Enrollment transaction) to inform the Enrollee of the effective date, provide information necessary to access benefits, and to explain the CICO rules. The Enrollee's coverage will be active on the effective date regardless of whether or not the Enrollee has received all the information by the effective date. It is expected that all of the items outlined in §30.4.1 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance will be sent prior to the effective date for Passive Enrollment.

## 2.3.5. Disenrollment

### 2.3.5.1. Voluntary Disenrollment

2.3.5.1.1. The CICO shall have a mechanism for receiving timely information about all Disenrollments from the CICO's plan, including the effective date of Disenrollment, from CMS and SCDHHS or its authorized agent. All Disenrollment-related transactions will be performed by SCDHHS or its authorized agent. Enrollees may elect to voluntarily disenroll from the CICO or the Demonstration at any time and enroll in another CICO, a Medicare Advantage plan, PACE (if eligible and resides within the appropriate geographic area); or may elect to receive services through Medicare fee-for-service and a prescription drug plan and to receive Medicaid services in accordance with the South Carolina State Plan and any waiver programs (if eligible). Disenrollment requests received by SCDHHS or its authorized agent, or by CMS or its CICO, either orally or in writing, by the last calendar day of the month will be effective on the first calendar day of the following month.

2.3.5.1.2. The CICO may not request Disenrollment on behalf of an Enrollee.

2.3.5.1.3. The CICO shall be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of Disenrollment.

### 2.3.5.2. Discretionary Involuntary Disenrollments

- 2.3.5.2.1. The CICO shall not request the Disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of treatment plan, medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs or take an Adverse Action in connection with an Enrollee who attempts to exercise, or is exercising, his or her Appeal or Grievance rights. Any attempts to seek to terminate Enrollment in violation of this Section 2.3.5 will be considered a breach of this Contract.
- 2.3.5.2.2. The CICO, however, may submit a written request, accompanied by the supporting documentation required by Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, to the CMT to disenroll an Enrollee, for cause.
- 2.3.5.2.3. For the purposes of implementing this Section 2.3.5.2, the CMT shall serve as the agent for CMS and SCDHHS. CMS and SCDHHS shall not have independent authority to review requests for discretionary Involuntary Disenrollment under this Section beyond their representation on the CMT. The CMT may approve a CICO request to disenroll a member for disruptive behavior only after the CICO has met the requirements of Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. If despite efforts by the CICO to, where appropriate, resolve and provide an opportunity for the Enrollee to cure the problems, the following exist:
  - 2.3.5.2.3.1. Consistent with Sections 40.3 and 40.4 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, the Participant engages in conduct or behavior that seriously impairs the CICO's ability to furnish services to either this Enrollee or other Enrollees, provided the CICO made and documented reasonable efforts to resolve the problems presented by the Enrollee and. Enrollee's behavior is determined to be unrelated to the reasons prohibited reasons for voluntary Disenrollment requests outlined in Section 2.3.5.2.1.

- 2.3.5.2.4. To support the CMT's evaluation of the CICO's requests for Involuntary Disenrollment, the CICO shall:
- 2.3.5.2.4.1. Comply with the advance notice and notice of intent requirements at 40.3.1 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance with an Advance Notice that explains that his/her continued behavior may result in Involuntary Disenrollment and that cessation of the undesirable behavior may prevent this action;
  - 2.3.5.2.4.2. Submit all documentation required by Sections 40.3 and 40.4 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance;
  - 2.3.5.2.4.3. In all cases, document what steps the CICO has taken to locate and engage the Enrollee, and the impact of or response to each attempt;
  - 2.3.5.2.4.4. Transfer Enrollee medical record information promptly to the new CICO or SCDHHS fee-for-service plan or Provider as appropriate upon Disenrollment of the Enrollee from the Demonstration or at the Enrollee's request to transfer to another CICO in accordance with Section 5.2.4.
- 2.3.5.2.5. The CMT will determine when and if a CICO's request to terminate the Enrollment of an Enrollee will be granted based on the criteria in this Section and in Sections 40.3 and 40.4 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance. In the event that the CMT approves a CICO's request for Involuntary Disenrollment for cause, the CMT will notify the State to send the Enrollee a Planned Action Notice as defined at 40.3.1, with a copy to the CMT. The State can submit the Disenrollment transaction to CMS only after providing the Planned Action Notice to the Enrollees described at 40.3.1 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.
- 2.3.5.2.6. Termination of an Enrollee's coverage shall take effect at 11:59 p.m. on the last day of the month following the month the Disenrollment is processed.

- 2.3.5.2.7. SCDHHS and CMS will develop a process to evaluate discretionary Involuntary Disenrollment requests. If the CMT determines that the CICO too frequently requests discretionary Involuntary Disenrollments for Enrollees, the CMT reserves the right to deny such requests and require the CICO to initiate steps to improve the CICO's ability to serve such Enrollees.
- 2.3.5.2.8. The CICO must make a reasonable effort to identify for the Enrollee, both verbally and in writing, those actions of the Enrollee that have interfered with the effective provision of Covered Services as well as explain what actions or procedures are acceptable. At minimum, these efforts must include the Advance Notice and Notice of Intent as described in the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.
- 2.3.5.2.9. The CICO shall give prior verbal and written notice to the Enrollee, including a right for an Appeal and with a copy to the CMT, of its intent to request Disenrollment. The written notice (Notice of Intent) shall advise the Enrollee that the request has been forwarded to the CMT for review and approval.

### 2.3.5.3. Required Involuntary Disenrollments

- 2.3.5.3.1. SCDHHS and CMS shall terminate an Enrollee's coverage upon the occurrence of any of the conditions enumerated in Section 40.2 of the 2013 Medicare-Medicaid Plan Enrollment and Disenrollment Guidance or upon the occurrence of any of the conditions described in this section. Except for the CMT's role in reviewing documentation related to an Enrollee's alleged material misrepresentation of information regarding third-party reimbursement coverage, as described in this section, the CMT shall not be responsible for processing Disenrollments under this section. Further, nothing in this section alters the obligations of the parties for administering Disenrollment transactions described elsewhere in this Contract.

2.3.5.3.2. The CICO shall notify SCDHHS or its authorized agent of any Enrollee whom the CICO believes is no longer eligible to remain enrolled in the CICO due to any of the following events that would give rise to ineligibility per CMS the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance, in order for SCDHHS or its authorized agent to disenroll the Enrollee.

2.3.5.3.2.1. The CICO shall notify SCDHHS when an Enrollee has health care insurance coverage with the CICO or any other carrier:

2.3.5.3.2.1.1. Within fifteen (15) Business Days when an Enrollee is verified as having Duplicate Coverage with the CICO, as defined herein.

2.3.5.3.2.1.2. Within fifteen (15) business days of the date when the CICO becomes aware that an Enrollee has any health care insurance coverage with any other insurance carrier. The CICO is not responsible for the determination of Comparable Coverage, as defined herein.

2.3.5.3.2.2. SCDHHS will involuntarily terminate the Enrollment of any Enrollee with Duplicate Coverage or Comparable Coverage as follows:

2.3.5.3.2.2.1. When the Enrollee has Duplicate Coverage that has been verified by SCDHHS, SCDHHS shall terminate Enrollment retroactively to the beginning of the month of Duplicate Coverage.

2.3.5.3.2.2.2. When the Enrollee has Comparable Coverage which has been verified by SCDHHS, SCDHHS shall terminate Enrollment prospectively.

2.3.5.3.2.3. The Enrollment of any Enrollee under this Contract shall be terminated if the Enrollee becomes ineligible for Enrollment due to a change in eligibility status. When an Enrollee's Enrollment is terminated for eligibility, the termination shall be effective:

- 2.3.5.3.2.3.1. The first (1st) day of the month following the month in which the eligibility is lost or person determined to be out of the Service Area;
- 2.3.5.3.2.4. Upon the Enrollee's death. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month in which the Enrollee dies. Termination may be retroactive to this date.
- 2.3.5.3.2.5. When an Enrollee remains out of the Service Area or for whom residence in the Service Area cannot be confirmed for more than six (6) consecutive months.
- 2.3.5.3.2.6. When an Enrollee no longer resides in the Service Area, except for a Participant living in the Service Area who is admitted to a nursing facility outside the Service Area and placement is not based on the family or social situation of the Enrollee. If an Enrollee is to be disenrolled at the request of the CICO under the provisions of this Section, the CICO must first provide documentation satisfactory to SCDHHS and CMS that the Enrollee no longer resides in the Service Area. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month prior to the month in which SCDHHS and CMS determine that the Enrollee no longer resides in the Service Area. Termination may be retroactive if SCDHHS and CMS are able to determine the month in which the Enrollee moved from the Service Area.
- 2.3.5.3.2.7. When CMS or SCDHHS is made aware that an Enrollee is incarcerated in a county jail, South Carolina Department of Corrections facility, or Federal penal institution. Termination of coverage shall take effect at 11:59 p.m. on the last day of the month during which the Enrollee was incarcerated.

2.3.5.3.2.8. The termination or expiration of this Contract terminates coverage for all Enrollees with the CICO. Termination will take effect at 11:59 p.m. on the last day of the month in which this Contract terminates or expires, unless otherwise agreed to, in writing, by the Parties.

2.3.5.3.2.9. When the CMT approves a request based on information sent from any party to the Demonstration showing that an Enrollee has materially misrepresented information regarding third-party reimbursement coverage according to Section 40.2.6 of the Medicare-Medicaid Plan Enrollment and Disenrollment Guidance.

#### 2.3.5.4. CICO Coverage of Services Following Disenrollment

2.3.5.4.1. An Enrollee whose Enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive Covered Services, at the CICO's expense, through the end of that month.

2.3.5.4.2. In no event will an Enrollee be entitled to receive services and benefits under this Contract after the last day of the month in which their Enrollment is terminated, except:

2.3.5.4.2.1. When the Enrollee is hospitalized at termination of Enrollment and continued payment is required in accord with the Section 2.8 of this contract;

2.3.5.4.2.2. For the provision of information and assistance to transition the Enrollee's care with another provider; or

2.3.5.4.2.3. As necessary to satisfy the results of an Appeal or hearing

2.3.5.4.3. Regardless of the procedures followed or the reason for termination, if an Enrollment request is granted, or the Enrollee's Enrollment is terminated by HCA for one of the reasons described in this Contract, the effective date of the Disenrollment will be no later than the first day of the second month following the month the request was made.



- 2.3.5.5. The CICO shall complete a safe discharge process for Disenrollments under this section
- 2.3.6. Initial Enrollee Contact and Orientation
  - 2.3.6.1. The CICO shall provide an orientation to Enrollees within thirty (30) calendar days of the initial date of Enrollment. The orientation shall include:
    - 2.3.6.1.1. Materials and a welcome call;
    - 2.3.6.1.2. For Enrollees without a current primary care provider (PCP) identified at the time of Enrollment, assisting the Enrollee to identify and if desired retain their current PCP or choose a PCP.
    - 2.3.6.1.3. Working with the Enrollee to schedule an Initial Health Screening (see Section 2.6); and
    - 2.3.6.1.4. Any pre-enrollment materials specified in Section 2.13.4 that, due to a late month Enrollment request, were not provided prior to the time of Enrollment.
  - 2.3.6.2. The CICO shall assist the Enrollee in choosing an in-network PCP when the Enrollee's current PCP is not in network and refuses to become a Network Provider or enter into a single-case out-of-network agreement where applicable (see Section 2.6.9.3.5).
    - 2.3.6.2.1. The Enrollee must choose a new PCP by the end of the one hundred eighty (180) day continuity of care period or after the ICP is developed. If the Enrollee has not chosen an in-network PCP by the end of the one hundred eight (180) day period, the CICO shall choose one for the Enrollee.
  - 2.3.6.3. The CICO shall make available to family members, caregivers, and designated representatives, as appropriate, any Enrollment and orientation materials upon request and with consent of the Enrollee.
  - 2.3.6.4. The CICO shall provide non-written orientation in a format such as telephone calls, home visits, video screenings, or group presentations to Enrollees for whom written materials are not appropriate.
  - 2.3.6.5. Notify its Enrollees:
    - 2.3.6.5.1. That translations of written information are available in Prevalent Languages;

- 2.3.6.5.2. That oral interpretation services are available free of charge for any language spoken by Enrollees and Eligible Beneficiaries;
  - 2.3.6.5.3. How Enrollees can access oral interpretation services;
  - 2.3.6.5.4. How Enrollees can access non-written materials described in Section 2.3.6.4 above; and
  - 2.3.6.5.5. How Enrollees can make a standing request to receive all future notifications and communication in a specified Alternative Format.
- 2.3.6.6. The CICO shall ensure that all orientation materials are provided in a manner and format that may be easily understood, including providing written materials in Prevalent Languages and oral interpretation services when requested.
- 2.3.6.7. The CICO shall ensure that documents for its Enrollees, such as the Enrollee handbook, are comprehensive yet written to comply with readability requirements. For the purposes of this Contract, no program information document shall be used unless it achieves a Flesch Total Readability Score of forty (40) or better (at or below a 6<sup>th</sup> grade reading level). The document must set forth the Flesch score and certify compliance with this standard. These requirements shall not apply to language that is mandated by federal or state laws, regulations or agencies. Additionally, the CICO shall ensure that written Enrollee material is available in Alternative Formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited. [42 C.F.R. § 438.10(d)(1)(ii)]
- 2.3.6.8. The CICO must make available Enrollee handbooks in Spanish and in languages other than English when five (5) percent of the CICO's enrolled population is non-English speaking and speaks a common language. The populations will be assessed by Demonstration regions and will only affect handbooks distributed in the affected region.

## 2.4. Covered Services

### 2.4.1. General

- 2.4.1.1. The CICO must arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. (See Covered Services in Appendix A.) Covered Services must be available to all Enrollees, as authorized by the CICO, where applicable. Covered Services will be

managed and coordinated by the CICO through the Multidisciplinary Team (MT) (see Section 2.5.3 )

- 2.4.1.2. The CICO will have discretion to use the capitated payment to offer flexible benefits, as specified in the Enrollee's ICP, as appropriate to address the Enrollee's needs.
- 2.4.1.3. Under the Demonstration, skilled nursing level of care may be provided in a long term care facility without a preceding qualifying acute care inpatient stay for Enrollees, when the provision of this level of care is clinically appropriate and can avert the need for an inpatient stay.
- 2.4.1.4. The CICO shall be allowed to use cost effective alternative services, whether listed as covered or non-covered or otherwise omitted from the Demonstration, when the use of such alternative services is medically appropriate and is cost effective. This may include, for example two instances in which an Enrollee does not meet the nursing facility level of care and is therefore ineligible for home and community based services (HCBS): the first includes the temporary use of home care services to facilitate a transition from an acute care setting back to the community; the other allows the use of HCBS to delay the need for nursing facility placement.
- 2.4.1.5. The CICO must provide the full range of Covered Services. If either Medicare or South Carolina Medicaid provides more expansive services than the other program does for a particular condition, type of illness, or diagnosis, the CICO must provide the most expansive set of services required by either program. The CICO may not limit or deny services to Enrollees based on Medicare or South Carolina Medicaid providing a more limited range of services than the other program.

#### 2.4.2. Excluded Services

- 2.4.2.1. The following services will be carved out from this Contract and will be provided in fee-for-service as described below.
  - 2.4.2.1.1. Medicare Hospice benefits;
  - 2.4.2.1.2. Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID);
  - 2.4.2.1.3. The Enrollee must meet the State's level of care for ICF-IIDs as certified by the South Carolina Department of Disabilities and Special Needs.
  - 2.4.2.1.4. Medicaid non-emergent transportation services.

- 2.4.2.1.4.1. The SCDHHS covers non-emergent transportation services for all Medicaid Enrollees through a contracted broker/coordinator .
- 2.4.2.1.5. Dental services not otherwise listed below. The CICO will be responsible for Medically Necessary procedures covered by Medicare and/or Medicaid including, but not limited to, the following:
  - 2.4.2.1.5.1. Emergency medical (CPT) procedures performed by oral surgeons.
  - 2.4.2.1.5.2. Covered dental procedures (CDT Codes) delivered in preparation for, or during the course of treatment for one or more of the following medical reasons will be considered for payment: organ transplants; oncology; radiation of the head and/or neck for cancer treatment; chemotherapy for cancer treatment; total joint replacement; heart valve replacement; trauma treatment performed in a hospital or ambulatory surgical center (ASC).
  - 2.4.2.1.5.3. The CICO must cover anesthesia and hospitalization for Medically Necessary dental services.
- 2.4.2.1.6. At its option, the CICO may cover certain additional dental services for Enrollees.
- 2.4.2.2. Services that are carved out must be:
  - 2.4.2.2.1. Both coordinated and incorporated in the ICP, as well as included in the MT discussions;
  - 2.4.2.2.2. Inclusive of Providers of the three carved-out services to participate in the MT sessions.
- 2.4.2.3. Enrollees can elect to remain in the Demonstration and receive one or more of these carved out services. A CICO may not disenroll someone from the Demonstration if s/he elects to receive one or more of these services.

## 2.5. Care Delivery Model

### 2.5.1. General

- 2.5.1.1. The CICO shall offer Care Management services to all Enrollees to ensure effective integration and coordination between the Medical Home and other Providers and services and to coordinate the full range of medical, behavioral health, and LTSS, as needed.
- 2.5.2. Home and Community Based Service Transition
  - 2.5.2.1. Responsibility for HCBS will be transitioned from SCDHHS to the CICO, as specified in more detail in Appendix C.
  - 2.5.2.2. The transition will consist of three (3) phases over which the CICO will assume greater responsibility for the oversight and provision of HCBS.
  - 2.5.2.3. The CICO will be required to pass a Benchmark Review prior to assuming the responsibilities specified for each of the phases.
  - 2.5.2.4. SCDHHS will transition and phase in HCBS authority and accountability over the course of the Demonstration. During Phase I of the Demonstration, SCDHHS will maintain contractual relationships with HCBS Providers. The CICO, however, will receive payment for these services and process Provider payments through Care Call. For Phase II, the CICO that has successfully completed the first HCBS Benchmark Review will assume contractual authority for Case Management services and most HCBS, in addition to the full continuum of Medicare and Medicaid Covered Services it is already providing. For Phase III, the CICO that has successfully completed the final HCBS Benchmark Review will provide all Case Management and HCBS and assume all contractual authority for the continuum of care under the Demonstration. Additional details regarding the phase-in, including the roles and responsibilities of CMS, SCDHHS and the CICO, is contained in Appendix C.
- 2.5.3. Multidisciplinary Team
  - 2.5.3.1. Every Enrollee shall have access to and input in the development of a MT to ensure the integration of the Enrollee's medical, behavioral health, psychosocial, and community-based or facility-based LTSS.
  - 2.5.3.2. The MT will be person-centered, built on the Enrollee's specific preferences and needs, and fulfill its responsibilities, including those related to service delivery, with transparency, individualization, accessibility, respect, linguistic and cultural competence, and dignity.
  - 2.5.3.3. MT Members

- 2.5.3.3.1. The MT must be comprised, first and foremost, of the Enrollee and/or his/her designee.
- 2.5.3.3.2. The Enrollee shall be encouraged to identify individuals that he/she would like to participate on the MT, including but not limited to family members, responsible parties, or other informal caregivers such as neighbors or friends.
- 2.5.3.3.3. The MT must also consist of the at least the following staff:
  - 2.5.3.3.3.1. A Care Coordinator who is accountable for coordination of all benefits and services the Enrollee may need. Care Coordinators will have prescribed caseload limits that vary based on risk-level (see Section 2.6.1 for information on risk-levels). The Care Coordinator serves as the lead MT member;
  - 2.5.3.3.3.2. The Enrollee's PCP or designee;
  - 2.5.3.3.3.3. The Enrollee's behavioral health clinician, if applicable;
  - 2.5.3.3.3.4. The Enrollee's LTSS Provider(s), if necessary including the following:
    - 2.5.3.3.3.4.1. Home Again transition coordinator, if applicable;
    - 2.5.3.3.3.4.2. HCBS Provider(s); and
    - 2.5.3.3.3.4.3. Waiver Case Manager: During Phase I of the HCBS transition, Medicaid Case Management Providers are subject to state contractual agreements that include provisions for mandatory participation in the waiver Case Management,
  - 2.5.3.3.3.5. A Pharmacist, if necessary;
  - 2.5.3.3.3.6. Hospital discharge planners and nursing facility representatives, if applicable.

2.5.3.3.4. As appropriate and at the discretion of the Enrollee, the MT also may include any or all of the following participants:

2.5.3.3.4.1. Registered nurse, specialist, and any other professional and support disciplines, including social workers, community health workers, and qualified peers, who may be able to provide subject matter expertise and input;

2.5.3.3.4.2. Advocates; and,

2.5.3.3.4.3. State agency or other case managers.

2.5.3.4. CICO Responsibilities related to the MT. The CICO shall:

2.5.3.4.1. Recruit, select, train, manage, and employ or contract with appropriate and qualified personnel, including PCPs, behavioral health clinicians, Care Coordinators, and LTSS providers, and will maintain staffing levels necessary to perform its responsibilities under the Contract;

2.5.3.4.2. Provide to all CICO staff who participate as members of the MT (upon initial participation in the MT and on an annual basis thereafter) the required training on the person-centered process planning processes, cultural competence, accessibility and accommodations, independent living and recovery, ADA/Olmstead requirements, and wellness principles, along with other required training, as specified by SCDHHS;

2.5.3.4.3. Offer trainings similar those described in Section 2.5.3.4.1 above to other members of the MT as appropriate;

2.5.3.4.4. Ensure that the MT is accessible to the Enrollee, including by providing alternatives to office visits, including, as appropriate, home visits, e-mail and telephone contact; and

2.5.3.4.5. Have a mechanism in place to allow Enrollees to directly access a specialist as appropriate for the Enrollee's condition and identified needs.

2.5.3.5. MT Responsibilities. The MT shall:

- 2.5.3.5.1. Be led by a Care Coordinator, or designee appointed by the Care Coordinator as necessary to cover in his/her absence;
- 2.5.3.5.2. Assist, as appropriate, in reviewing and completing the Comprehensive Assessments and reassessments.
- 2.5.3.5.3. With the Enrollee and/or Enrollee's designated representative, if any, and with all the appropriate MT members, including the Enrollee, develop and review an ICP that includes treatment goals (medical, functional, and social) and measure progress and success in meeting those goals in accordance with the timelines identified in Section 2.6.6 Individualized Care Plans (ICPs), but no less than annually.
- 2.5.3.5.4. On an ongoing basis, recommend coordination, consultation with and advisement of acute, specialty, LTSS and behavioral health Providers about ICPs and clinically appropriate interventions;
- 2.5.3.5.5. Promote independent functioning and preventive treatment for the Enrollee and assure the provision of services in the most appropriate, least restrictive environment;
- 2.5.3.5.6. Document and assure compliance with advance directives about the Enrollee's wishes for future treatment and healthcare decisions and assure compliance with the provisions of the Patient Self-Determination Act of 1990;
- 2.5.3.5.7. Review Enrollee Medical Record(s), including, but not limited to appropriate and timely entries about the care provided, diagnosis determined, medications prescribed, and treatment plans developed and should designate the physical location of the record(s) for each Enrollee.
- 2.5.3.5.8. Ensure the information reviewed is based upon frequent and meaningful contact with the Enrollee through various methods, including, but not limited to, face-to-face visits, email, and telephone options, as appropriate to the Enrollee's needs and risk-level.
- 2.5.3.5.9. Identify appropriate interventions as necessary through assessment or at the request of the Enrollee.



- 2.5.3.5.10. Assist in the implementation and monitoring of the ICP.
- 2.5.3.5.11. Ensure the Care Coordinator documents changes in the Enrollees condition(s) in the Enrollee's Medical Record(s) consistent with documentation polices established by the CICO. The Enrollee Medical Record should reflect the recommendations of the MT.
- 2.5.3.5.12. Operate within their professional scope of practice, appropriate for responding to and meeting the Enrollee's needs, and complying with the state's licensure/credentialing requirements.
- 2.5.3.5.13. Support Providers in Medical Homes, assist in assuring integration of services and coordination of care across the spectrum of the healthcare system, and help provide Care Management for Enrollees.
- 2.5.3.5.14. Provide or recommend Enrollee health education on complex clinical conditions and wellness/prevention programs.
- 2.5.3.5.15. Provide medication management.
- 2.5.3.5.16. Assure any prior authorizations are made within forty-eight (48) hours of readiness for discharge to ensure that delays do not adversely affect discharge planning at the hospital or service delivery when Enrollees are in a hospital awaiting discharge because of a need for community-based services or nursing facility placement authorization.
- 2.5.3.5.17. Make the following supports available, depending on the Enrollee's needs and preferences:
  - 2.5.3.5.17.1. A single, toll-free point of contact for all of the Enrollee's questions;
  - 2.5.3.5.17.2. Ability to develop, maintain, and monitor the ICP;
  - 2.5.3.5.17.3. Assurance that referrals result in timely appointments;
  - 2.5.3.5.17.4. Communication and education regarding available services and community resources;

- 2.5.3.5.17.5. Assistance in developing self-management skills to effectively access and use services;
- 2.5.3.5.17.6. Assurance that the Enrollee receives needed medical and behavioral services, preventative services, medications, community-based or facility-based LTSS, reasonable accommodations, social services, and enhanced benefits. The benefits and services that the MT monitors include, but are not limited to:
  - 2.5.3.5.17.6.1. The integration of primary, specialty, behavioral health, LTSS, and referrals to community-based resources, as appropriate;
  - 2.5.3.5.17.6.2. Assistance from Care Coordinators in setting up appointments;
  - 2.5.3.5.17.6.3. In-person contacts, as appropriate;
  - 2.5.3.5.17.6.4. Strong working relationships between Care Coordinators and physicians;
  - 2.5.3.5.17.6.5. Evidence-based Enrollee education programs, including health education on complex clinical conditions and wellness/prevention programs; and
  - 2.5.3.5.17.6.6. Transportation, as needed.
- 2.5.3.5.17.7. Continuous monitoring of functional and health status; and
- 2.5.3.5.17.8. Seamless transitions of care across specialties and settings.
- 2.5.3.5.18. Inform HCBS Enrollees of the consumer-directed personal assistance option at initial and annual care planning meetings
- 2.5.3.5.19. Cooperate with, collaborate with, and facilitate Enrollees' access to the Demonstration Ombudsman.
- 2.5.3.6. The MT's decisions serve as service authorizations, may not be modified by the CICO outside of the MT, and are appealable by the Enrollees, their Providers (as permitted for Medicare and Medicaid),

and their representatives. Periodic audits of an Enrollee's ICP may be conducted to determine the clinical appropriateness of service authorizations. MT service planning, coverage determinations, care coordination, and Care Management will be delineated in the Enrollee's ICP and will be based on the assessed needs and articulated preferences of the Enrollee.

#### 2.5.4. Care Coordinators

2.5.4.1. As the lead member of the MT, the Care Coordinator must execute the following responsibilities:

- 2.5.4.1.1. Serve as the single point of contact for an Enrollee to the CICO and the MT;
- 2.5.4.1.2. Communicate with other MT members regarding the medical, functional, and psychosocial condition of Enrollees;
- 2.5.4.1.3. Conduct or participate in the Comprehensive Assessment process for ICP development;
- 2.5.4.1.4. Ensure MT meetings and conference calls are held periodically based on the acuity level and risk stratification of the Enrollees;
- 2.5.4.1.5. Monitor the provision of services, including outcomes, assessing appropriate changes or additions to services, and making necessary referrals, as needed for the Enrollee; and
- 2.5.4.1.6. Ensure that appropriate mechanisms are in place to receive Enrollee input—including complaints, Grievances, and Appeals—and to ensure secure communication among relevant parties.
- 2.5.4.1.7. With the Enrollee and/or Enrollee's designated representative, if any, and with all the appropriate MT members, including the Enrollee, develop an ICP, that includes treatment goals (medical, functional, and social) and measure progress and success in meeting those goals;

- 2.5.4.1.8. Communicate with the Enrollee and, in accordance with the Enrollee's preferences, the Enrollee's family members, and informal caregiver(s), if any, about the Enrollee's medical, social, and psychological needs on a monthly basis to include a phone call or face-to-face meeting, depending upon the Enrollee's needs and preferences; and
  - 2.5.4.1.8.1. For Enrollees stratified as high-risk, the Care Coordinator must engage in contact with the Enrollee at least once every thirty (30) calendar days, or as specified in the HCBS waivers if more frequent and applicable; and
  - 2.5.4.1.8.2. For Enrollees stratified as low- or moderate-risk, the Care Coordinator must engage in contact with the Enrollee at least once every sixty (60) calendar days.
- 2.5.4.1.9. Document changes in the Enrollees' condition(s) in the Enrollees' Medical Record(s) consistent with the documentation policies established by the CICO.

#### 2.5.4.2. Care Coordinator Qualification Requirements

- 2.5.4.2.1. Demonstrated experience, qualifications and training appropriate to the needs of the Enrollee, and the CICO must establish policies for appropriate assignment of Care Coordinators;
- 2.5.4.2.2. Demonstrated competency to communicate with Enrollees who have complex medical needs and may have communication challenges;
- 2.5.4.2.3. Experience in navigating resources and computer systems to access information;
- 2.5.4.2.4. Knowledge of physical health, the aging process and associated losses, appropriate support services in the community, frequently used medications and their potential negative side-effects, depression, challenging behaviors, Alzheimer's disease and other disease-related dementias, behavioral health, and issues related to accessing and using durable medical equipment as appropriate; and

2.5.4.2.5. At minimum, Care Coordinators must have a bachelor's degree, preferably in a health or social services related area.

2.5.4.2.5.1. Care Coordinators who serve Enrollees assigned to moderate to high risk levels must have a clinical background and may also have community-based experience working with the elderly, persons with disabilities, including developmental disabilities, and person-centered planning approaches.

2.5.4.2.5.2. Care Coordinators who serve Enrollees assigned to lower risk levels are not required to have a clinical background.

2.5.4.3. Care Coordinator Training

2.5.4.3.1. The CICO is responsible for the appropriate training for the Care Coordinator and verifying that the training or any certifications remain current. The CICO must have policies in place to address non-compliance with training by the Care Coordinators. At a minimum, educational and training topics will include person-centered planning processes, cultural and disability competencies, compliance with the ADA and independent living and recovery and wellness philosophies.

2.5.4.4. Care Coordinator Assignments and Change Requests

2.5.4.4.1. The CICO shall assign to every Enrollee a Care Coordinator with the appropriate experience and qualifications based on an Enrollee's assigned risk level and individual needs (e.g., communication, cognitive, or other barriers).

2.5.4.4.2. The CICO must have a process to ensure that an Enrollee and/or his/her caregiver is able to request a change in his or her Care Coordinator at any time.

2.5.4.4.3. The CICO will make Care Coordinator caseload determinations based on risk-stratification of Enrollees utilizing a protocol which promotes quality care outcomes. The CICO will also identify a comprehensive list of elements that impact caseload determination in diverse care settings, including:

- 2.5.4.4.3.1. The CICO must ensure that the Care Coordinator's caseload is reasonable to provide appropriate care coordination and care management in accordance with the model of care requirements for CICOs.
- 2.5.4.4.3.2. Care Coordinators shall maintain continuous monitoring and review of Enrollees' health statuses as frequently as appropriate (See Table in Appendix K).

## 2.5.5. Care Coordination

- 2.5.5.1. The CICO shall offer person-centered care management to all Enrollees to ensure effective linkages and coordination between the Medical Home and other Providers and services and to coordinate the full range of medical and behavioral health services, preventive services, medications, LTSS, social supports, and enhanced benefits as needed, both within and outside the CICO. All Enrollees will have access to a Care Coordinator and MT based on their needs and preferences, and will be encouraged to participate in decision making with respect to their care. At minimum, Care Coordination will include:
  - 2.5.5.1.1.1. Access to a single, toll-free point of contact for all questions;
  - 2.5.5.1.1.2. Development of an ICP that is periodically reviewed, monitored, and updated;
  - 2.5.5.1.1.3. Disease self-management and coaching;
  - 2.5.5.1.1.4. Medication review, including reconciliation during care transitions;
  - 2.5.5.1.1.5. Periodic monitoring of health, functional and mental status along with pain and fall screenings;
  - 2.5.5.1.1.6. Provision of services in the least restrictive setting and transition support across and between specialists and care settings;
  - 2.5.5.1.1.7. Connecting Enrollees to services that promote community living, integration, and help to delay or avoid nursing facility placement;

- 2.5.5.1.1.8. Coordinating with social service agencies (e.g., local departments of health, social services, aging, and other community based organizations) and referring Enrollees to state, local and/or other community resources;
  - 2.5.5.1.1.9. Supporting and assisting Enrollees to be in a position to develop natural support;
  - 2.5.5.1.1.10. Identifying and educating Enrollees who utilize services inappropriately (e.g., overutilization of emergent care services) and provide continuing education as needed.
  - 2.5.5.1.1.11. Utilizing data analyses to measure medical compliance and develop strategies to influence overall health; and
  - 2.5.5.1.1.12. Collaborating with nursing facilities to promote adoption of evidence-based interventions to reduce avoidable hospitalization and management of chronic conditions.
- 2.5.5.2. The CICO shall coordinate with entities that currently perform Care Management. The CICO shall contract with entities that offer support services to Enrollees in the Demonstration.
- 2.5.5.2.1. These partnerships may include the use of medical homes sub-capitation, shared savings, performance incentives;
  - 2.5.5.2.2. Entities can include, but are not limited to adult day care centers and nursing facilities; and
  - 2.5.5.2.3. The CICO must also coordinate with existing Care Management services to avoid duplication.
  - 2.5.5.2.4. The CICO will be required to have a process in place to facilitate Medical Homes advancing toward patient-centered medical home (PCMH) recognition through NCQA. To ensure adequacy of PCMH Providers, the CICO will encourage development of PCMH standards using the incentive structure outlined in the [Medicaid Managed Care Policy and Procedures Guide \(https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp\)](https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp).

## 2.5.6. Coordination Tools: Phoenix/Care Call

- 2.5.6.1. The CICO will have access to Phoenix/Care Call, SCDHHS's automated waiver Case Management and service authorization system. The data in this system delineate the services authorized and documents service delivery. The system will serve as an electronic record for all assessments, ICPs, Provider information, caregiver support systems, and other administrative components, Case Management, and quality assurance activities. In addition, this system automates prior authorization, real time service monitoring and billing for HCBS.
- 2.5.6.2. Both the Comprehensive Assessment and Long Term Care Assessment (LTC Assessment) tool will be managed in SCDHHS's automated Case Management system, Phoenix, which maintains records of a number of critical functions, including all intake, assessment, and care planning activities. Information from the initial health screen will feed into both the comprehensive LTC Assessment tools.

## 2.5.7. Health Promotion and Wellness Activities

- 2.5.7.1. The CICO will promote overall health and wellness, thorough activities that will increase independence.
- 2.5.7.2. The CICO must provide a range of health promotion and wellness informational activities for Enrollees, their family members, and other informal caregivers. The focus and content of this information must be relevant to the specific health status needs and high-risk behavioral in the Medicare-Medicaid population. Interpreter services must be available for Enrollees who are not proficient in English. Examples of health promotion and wellness topics include, but are not limited to the following:
  - 2.5.7.2.1. Chronic condition self-management;
  - 2.5.7.2.2. Smoking cessation;
  - 2.5.7.2.3. Fall prevention;
  - 2.5.7.2.4. Caregiver support;
  - 2.5.7.2.5. Nutrition;
  - 2.5.7.2.6. Prevention and treatment of alcohol and substance abuse.



- 2.5.7.2.7. Emotional and mental health;
- 2.5.7.2.8. Medication management;
- 2.5.7.2.9. Fitness activities;
- 2.5.7.2.10. Advance disease planning; and
- 2.5.7.2.11. Emergency preparedness;

2.5.7.3. The CICO shall encourage PCPs to provide health education to Enrollees. The CICO shall ensure that Providers have the preventive care, disease-specific and plan services information necessary to support Enrollee education in an effort to promote compliance with treatment directives and to encourage self-directed care.

## 2.6. Enrollee Stratification, Assessments, and Care

### 2.6.1. Enrollee Stratification

2.6.1.1. The CICO can supplement the initial health screening with predictive modeling and surveillance data to stratify Enrollees as low, moderate, or high risk.

2.6.1.2. Enrollees in one of the Demonstration's three HCBS waivers are automatically stratified as high risk.

2.6.1.2.1. The CICO will determine the parameters and definitions for other Enrollees defined as high risk as well as definitions for low or moderate risk Enrollees.

2.6.1.2.2. These levels of stratification should be based on an Enrollees risk for long term care institutionalization and/or avoidable hospitalization.

2.6.1.3. Utilizing Enrollee demographics, medical conditions, functional status, care patterns, resource utilization data along with hierarchical condition categories (HCC) risk scores.

### 2.6.2. Initial Health Screen

2.6.2.1. The Initial Health Screen will collect information about the Enrollee's medical, psychosocial, LTSS, functional, and cognitive needs, and medical and behavioral health (including substance abuse) history.

2.6.2.2. Initial Health Screens must be administered to all new Enrollees within thirty (30) calendar days of Enrollment.

- 2.6.2.3. The CICO may forego an Enrollee's Initial Health Screen if completing the Comprehensive Assessment within sixty (60) calendar days of Enrollment.
  - 2.6.2.4. SCDHHS will collaborate with the CICOs to develop a universal Initial Health Screen tool. The Initial Health Screen will contain domain elements to identify potential LTSS needs and to determine the necessity of a LTC Assessment.
  - 2.6.2.5. This tool may be administered either in-person or telephonically.
- 2.6.3. Comprehensive Assessments
- 2.6.3.1. Each Enrollee shall receive, and be an active participant in, a timely Comprehensive Assessment of medical, behavioral health, community-based or facility-based LTSS, and social needs completed by the Care Management team.
  - 2.6.3.2. The CICO must use Phoenix, SCDHHS's automated Case Management system, to record the Comprehensive Assessments and to track the Long Term Care Assessments (as described in Section 2.6.4 Long Term Care Assessments).
  - 2.6.3.3. The Comprehensive Assessment will be performed using the state's uniform assessment tools.
    - 2.6.3.3.1. Assessment domains will include, but not be limited to, the following: social, functional, medical, behavioral, wellness and prevention domains, caregiver status and capabilities, as well as the Enrollee's preferences, strengths, and goals.
  - 2.6.3.4. The CICO will complete the Comprehensive Assessment using information from the initial health screen (described in Section 2.6.2 Initial Health Screen), comprehensive data sources, and input from the Enrollee, Providers, and family/caregivers.
  - 2.6.3.5. Assessments will be completed by qualified, trained health professionals who possess a professional scope of practice, licensure, and/or credentials appropriate for responding to or managing the Enrollee's needs. Examples of health professionals who may complete portions or all of the assessment include, but are not limited to:
    - 2.6.3.5.1. Registered nurses,
    - 2.6.3.5.2. Licensed practical nurses (under the supervision of registered nurses),

- 2.6.3.5.3. Social workers,
  - 2.6.3.5.4. Medicaid case managers,
  - 2.6.3.5.5. Certified geriatric care managers,
  - 2.6.3.5.6. Certified community health workers
- 2.6.3.6. The CICO will use the results of the Comprehensive Assessment to confirm the appropriate acuity or risk stratification level for the Enrollee and as the basis for developing the integrated ICP.
- 2.6.3.7. The Enrollee will continue to receive any community-based or facility-based LTSS (i.e., respite care) in any existing waiver service plan (s) prior to the Comprehensive Assessment or reassessment. The CICO will adhere to all transition requirements for services, as outlined in Section 2.6.9.
- 2.6.3.8. Timing of Comprehensive Assessments: All Enrollees will receive a Comprehensive Assessment to be completed within the following timeframes:
- 2.6.3.8.1. Enrollees stratified as high risk: within sixty (60) days of Enrollment;
  - 2.6.3.8.2. Enrollees stratified as moderate risk: within sixty (60) days of Enrollment; and
  - 2.6.3.8.3. Enrollees stratified as low risk: within ninety (90) days of Enrollment.
- 2.6.3.9. The CICO must ensure that a reassessment and an ICP update are performed:
- 2.6.3.9.1. As warranted by the Enrollee's condition but at least every twelve (12) months after the initial assessment completion date;
  - 2.6.3.9.2. When there is a change in the Enrollee's health status or needs;
  - 2.6.3.9.3. As requested by the Enrollee, his/her caregiver, or his/her provider; and
  - 2.6.3.9.4. Upon any of the following trigger events:
    - 2.6.3.9.4.1. A hospital admission;

- 2.6.3.9.4.2. Transition between care settings;
  - 2.6.3.9.4.3. Change in functional status;
  - 2.6.3.9.4.4. Loss of a primary caregiver or an informal caregiver who contributes substantially to the Enrollee's care;
  - 2.6.3.9.4.5. Change in, or addition of a, diagnosis; and
  - 2.6.3.9.4.6. As requested by a member of the MT who observes a change that requires further investigation.
- 2.6.3.10. Components of the assessment may be updated by the MT as warranted by minor changes on the Enrollee conditions.
- 2.6.3.11. The CICO will analyze surveillance data of all Enrollees monthly, including Care Call reports for persons receiving HCBS, to identify acuity and risk level changes. As acuity and risk levels change, reassessments will be completed as necessary and the ICP interventions updated.
- 2.6.3.11.1. The CICO shall identify Enrollees through referrals, transition information, service authorizations, alerts, memos, assessment results, and from families, caregivers, Providers, community organizations and CICO personnel as well as other mechanisms deemed appropriate by the CICO.
- 2.6.3.12. The CICO shall notify PCPs of Enrollment of any new Enrollee who has not completed a Comprehensive Assessment within the time period set forth above and whom the CICO has been unable to contact. The CICO shall encourage PCPs to conduct outreach to these Enrollees and to schedule visits.
- 2.6.4. Long Term Care Assessments
- 2.6.4.1. SCDHHS will conduct all Long Term Care Assessments and level of care determinations for both HCBS waiver and nursing facility services; final results will be recorded in Phoenix.
  - 2.6.4.2. CICO must coordinate with SCDHHS Community Long Term Care (CLTC) staff who perform the LTC Assessments.

- 2.6.4.2.1. CICO must ensure that all Enrollees who need a LTC Assessment are referred to CLTC within 24 hours of the completion of the Comprehensive Assessment, in which the need was identified. LTC Assessments are conducted for all Enrollees who are identified as high risk (as described in Section 2.6.1) or whose Comprehensive Assessments indicate a potential need for long term care services.
- 2.6.4.2.2. CICO must ensure that the Comprehensive Assessment and LTC Assessment are conducted concurrently, when possible.
- 2.6.4.2.3. The CICO will submit a referral for LTC Assessment via Phoenix, which will be received by the SCDHHS CLTC staff.
- 2.6.4.3. The CICO must use Phoenix, , to track LTC Assessments.
  - 2.6.4.3.1. The CICO will receive a notification via Phoenix when an Enrollee is scheduled to receive an LTC Assessment.
  - 2.6.4.3.2. The CICO will receive a second notification via Phoenix when the LTC Assessment and the level of care determination are complete.
  - 2.6.4.3.3. SCDHHS will provide the CICO, via Phoenix, with the most recent LTC Assessments and HCBS service plans for Enrollees who are also participants in one of the three designated State HCBS waiver programs.
    - 2.6.4.3.3.1. The CICO will have immediate, real time access to this information through the Phoenix system.
    - 2.6.4.3.3.2. Enrollees with a current and up-to-date LTC Assessment are not required to undergo a second assessment until such time as an annual reassessment is due. CICOs will gain the ability to perform reassessments after passing a Benchmark Review prior to implementation of the second transition phase of HCBS
- 2.6.5. Long Term Care Reassessments
  - 2.6.5.1. The CICO will conduct a face-to-face LTC Reassessments for Enrollees

- 2.6.5.1.1. As warranted by the Enrollee's condition but at least every twelve (12) months after the initial LTC Assessment completion date;
- 2.6.5.1.2. When there is a change in the Enrollee's health status or needs;
- 2.6.5.1.3. As requested by the Enrollee, his/her caregiver, or his/her Provider; and
- 2.6.5.1.4. Upon any of the following trigger events:
  - 2.6.5.1.4.1. A hospital admission;
  - 2.6.5.1.4.2. Transition between care settings;
  - 2.6.5.1.4.3. Change in functional status;
  - 2.6.5.1.4.4. Loss of a primary caregiver or an informal caregiver who contributes substantially to the Enrollee's care;
  - 2.6.5.1.4.5. Change in or addition of a diagnosis; and
  - 2.6.5.1.4.6. As requested by a member of the MT who observes a change that requires further investigation.

## 2.6.6. Individualized Care Plans (ICPs)

- 2.6.6.1. Following the Comprehensive Assessment (as described in Section 2.6.3 Comprehensive Assessment), the CICO shall assign a Care Coordinator who works with the Enrollee, his/her family supports, Providers, and other MT members to develop a comprehensive, person-centered, written ICP for each Enrollee. CICOs must allow Enrollees to request and be assigned a new Care Coordinator.
- 2.6.6.2. Every Enrollee must have an ICP, unless the Enrollee refuses and such refusal is documented by the Care Coordinator in Phoenix.
- 2.6.6.3. The CICO must complete each Enrollee's initial ICP within ninety (90) calendar days of Enrollment.
- 2.6.6.4. The CICO must provide the Enrollee with a copy of his or her ICP.
- 2.6.6.5. ICP Monitoring

- 2.6.6.5.1. The CICO must review ICPs of high-risk Enrollees at least every thirty (30) calendar days.
- 2.6.6.5.2. The CICO must review ICPs of moderate-risk Enrollees at least every ninety (90) calendar days.
- 2.6.6.5.3. The CICO must review ICPs of low-risk Enrollees at least every one hundred and twenty (120) calendar days.
- 2.6.6.6. The CICO must update an Enrollee's ICP every three-hundred and sixty-five (365) calendar days (at minimum), or more frequently if the Enrollee's condition warrants or if the Enrollee requests a change.
- 2.6.6.7. The ICP must:
  - 2.6.6.7.1. Include current and unique psychosocial and medical needs and history of the Enrollee, as well as the Enrollee's functional level, behavioral health needs, language, culture, and support systems;
  - 2.6.6.7.2. Include identifiable and measurable short- and long-term treatment and service goals and interventions to address the Enrollee's needs and preferences and to facilitate monitoring of the Enrollee's progress and evolving service needs;
  - 2.6.6.7.3. Include expected outcomes with completion timeframes;
  - 2.6.6.7.4. Include opportunities for input from the Enrollee, his/her designee, and the MT during the development, implementation, and ongoing assessment of ICP;
  - 2.6.6.7.5. Include a risk assessment that identifies and evaluates risks associated with the Enrollee's care. Factors considered include, but are not limited to:
    - 2.6.6.7.5.1. The potential for deterioration of the Enrollee's health status;
    - 2.6.6.7.5.2. The Enrollee's ability to comprehend risk;
    - 2.6.6.7.5.3. Caregiver qualifications and risks associated with burn-out or the ability to no longer perform duties;

- 2.6.6.7.5.4. Appropriateness of the residence for the Enrollee and reasonable accommodations; and,
- 2.6.6.7.5.5. Behavioral or other compliance risks.
- 2.6.6.7.6. Follow conflict-free guidelines for contracted entities participating in the ICP development process so that these entities offer choices to the Enrollee regarding the services and supports they receive and from available alternatives;
- 2.6.6.7.7. Include a process by which the Enrollee or his/her designee can request changes to the ICP;
- 2.6.6.7.8. Record the alternative HCBS and settings that were considered by the Enrollee; and
- 2.6.6.7.9. Grant Enrollees no less than Appeal rights provided for under Medicaid statute, regulation, and policy, and as outlined in Section 2.11.
- 2.6.6.7.10. Include, as appropriate, the following elements:
  - 2.6.6.7.10.1. The Enrollee's personal or cultural preferences, such as types or amounts of services;
  - 2.6.6.7.10.2. The Enrollee's preference of Providers and any preferred characteristics, such as gender or language;
  - 2.6.6.7.10.3. The Enrollee's living arrangements;
  - 2.6.6.7.10.4. Covered items and services and non-covered items and services to address each identified need;
  - 2.6.6.7.10.5. Participation in the self-directed attendant care option;
  - 2.6.6.7.10.6. MT service planning, coverage determinations, care coordination, and care management;
  - 2.6.6.7.10.7. Actions and interventions necessary to achieve the Enrollee's objectives;
  - 2.6.6.7.10.8. Follow-up and evaluation;
  - 2.6.6.7.10.9. Collaborative approaches to be used;



- 2.6.6.7.10.10. Desired outcome and goals, both clinical and non-clinical;
- 2.6.6.7.10.11. Barriers or obstacles, including unmet needs;
- 2.6.6.7.10.12. Responsible parties;
- 2.6.6.7.10.13. Standing Referrals;
- 2.6.6.7.10.14. Community resources;
- 2.6.6.7.10.15. Reasonable accommodations;
- 2.6.6.7.10.16. Informal supports;
- 2.6.6.7.10.17. Timeframes for completing actions;
- 2.6.6.7.10.18. Status of the Enrollee's goals;
- 2.6.6.7.10.19. Home visits as necessary and appropriate for Enrollees who are homebound ("confined to his home" as defined in 42 U.S.C. § 1395n(a)(2)), who have physical or cognitive disabilities, or who may be at increased risk for Abuse, neglect, or exploitation;
- 2.6.6.7.10.20. For Enrollees receiving HCBS, a back-up plan arrangements and missed visits for critical services;
- 2.6.6.7.10.21. Emergency preparedness plan;
- 2.6.6.7.10.22. Crisis plans for an Enrollee with behavioral health conditions; and,
- 2.6.6.7.10.23. Wellness/prevention program plans including, but not limited to, the following:
  - 2.6.6.7.10.23.1. Chronic condition self-management;
  - 2.6.6.7.10.23.2. Smoking cessation;
  - 2.6.6.7.10.23.3. Falls prevention;
  - 2.6.6.7.10.23.4. Screening for depression and other significant behavioral conditions;
  - 2.6.6.7.10.23.5. Nutrition; and

2.6.6.7.10.23.6. Prevention and treatment of alcohol and substance Abuse.

2.6.6.8. The CICO will monitor each Enrollee's ICP and any gaps in care will be addressed in an integrated manner by the MT, including any necessary revisions to the ICP.

2.6.7. Waiver Service Plans

2.6.7.1. During Phase I of the transition of HCBS authority (further described in Section 2.5.2 and Appendix C), SCDHHS maintains responsibility for developing the Waiver Service Plan. The Waiver Case Manager will complete the Waiver Service Plan and make recommendations for service authorizations as is currently done in Phoenix.

2.6.7.1.1. The CICO will have a formal process by which they can provide input or ask questions about the Waiver Service Plan.

2.6.7.1.1.1. A three-way conference will be conducted among the Waiver Case Manager, SCDHHS staff reviewer, and CICO designee to discuss elements in the Waiver Service Plan and the recommended service levels.

2.6.7.1.1.2. This conference may be conducted through telephonic, face-to-face, or electronic interactions (e.g., video conferencing) depending on the complexity of the case.

2.6.7.1.1.3. If there is disagreement about the Waiver Service Plan or the level of authorized services, the CICO may request a review from the Demonstration's independent Ombudsman who has the authority to make a final decision that best meets the needs of the Enrollee.

2.6.7.1.2. The Waiver Case Manager must collaborate with the Enrollee's Care Coordinator to ensure HCBS and the Waiver Service Plan is fully integrated into the ICP.

2.6.7.2. During Phases II and III of the HCBS transition (further described in Section 2.5.2 and Appendix C), the CICO is responsible for developing the Waiver Service Plan with concurrence from SCDHHS long term care staff. The CICO will complete the Waiver Service Plan and make recommendations for service authorizations in Phoenix.

## 2.6.8. Self-directed Care

2.6.8.1. The CICO will provide, through subcontract, client directed personal care assistance. Attendant care services are provided by qualified individuals, including specified family members, to help Enrollees by offering support for activities of daily living and monitoring the medical condition of Enrollees. The kinds of activities that an attendant Provider performs include the following:

2.6.8.1.1. Assistance with personal hygiene, feeding, bathing, toileting, ambulation, transferring, and meal preparation;

2.6.8.1.2. Encouraging clients to adhere to specially prescribed diets;

2.6.8.1.3. General housekeeping duties;

2.6.8.1.4. Shopping assistance;

2.6.8.1.5. Assistance with communication; and

2.6.8.1.6. Monitoring medication.

2.6.8.2. The CICO will support Enrollees in directing their own care and ICP development.

2.6.8.3. Notification of Self-Direction Options

2.6.8.3.1. Enrollees must be informed of the option to self-direct their own services at each Comprehensive Assessment and review of Comprehensive Assessment.

2.6.8.3.2. The MT must inform Enrollees of the option to self-direct their services when their ICPs are updated.

2.6.8.3.3. Explanations of the self-direction option must:

2.6.8.3.3.1. Make clear that self-direction of services is voluntary and that Enrollees can choose the extent to which they would like to self-direct their services;

2.6.8.3.3.2. Provide the options to select self-directed supports or services; and

- 2.6.8.3.3.3. Provide an overview of the supports and resources available to assist Enrollees to participate to the extent desired in self-direction.
- 2.6.8.4. The CICO's policies regarding self-direction must conform to SCDHHS requirements, including:
  - 2.6.8.4.1. Reimbursement for personal care, attendant care, and companion services may be made via SCDHHS's financial management Fiscal Employer Agent, Public Partnership Limited (PPL), to certain family members who meet the South Carolina Medicaid Provider qualifications.
    - 2.6.8.4.1.1. The spouse of the Enrollee, or any other legally responsible guardian of an Enrollee, cannot be reimbursed.
    - 2.6.8.4.1.2. In addition, family members who are primary caregivers will not be reimbursed for respite and/or companion services.
    - 2.6.8.4.1.3. Providers of self-directed services must meet the qualification of providers of personal assistance as outlined under 42 CFR 441.478.
  - 2.6.8.4.2. The CICO is responsible for ensuring that the prospective Provider provides results of a tuberculosis purified protein derivative (PPD) test. If the Provider has had a past positive result, documentation of the past positive and chest x-ray results is required. A Signs and Symptoms Questionnaire for Providers is required for those who have tested positive previously.
  - 2.6.8.4.3. The CICO is responsible to ensuring that the prospective Provider has had a South Carolina criminal history background check conducted by the South Carolina Law Enforcement Division (SLED). This includes retaining the required photocopy of a state identification or driver's license and photocopy of the Social Security card is required. Both documents must be in the same name.

2.6.8.4.3.1. All criminal background checks must include all data for the individual with no limit on the timeframe being searched. Criminal background checks that cover a specific time period such as seven (7) or ten (10) year searches are not acceptable. The criminal background check must include statewide (South Carolina) data. Potential employees with felony convictions within the last ten (10) years cannot provide services to Enrollees or work in an administrative/office position. Potential employees with non-violent felonies dating back ten (10) or more years can provide services to Enrollees under the following circumstances:

2.6.8.4.3.1.1. Enrollee/responsible party must be notified of the aide's criminal background, i.e. felony conviction, and year of conviction;

2.6.8.4.3.1.2. Provider must obtain a written statement, signed by the Enrollee/responsible party acknowledging awareness of the aide's criminal background and agreement to have the aide provide care; this statement must be placed in the participant record.

2.6.8.4.3.1.3. Potential administrative/office employees with non-violent felony convictions dating back ten (10) or more years can work in the agency at the Provider's discretion.

2.6.8.4.4. Hiring of employees with misdemeanor convictions will be at the Provider's discretion. Employees hired prior to July 1, 2007, and continuously employed since then will not be required to have a criminal background check. The CICO is required to ensure that the requirements of a South Carolina Certified Nurse Aide Registry check and Office of Inspector General List of Excluded Individuals/Entities (LEIE) Exclusions Program check are met.

2.6.8.4.5. The CICO must comply with the provision regarding the supervision of care for attendant. A supervisor is designated and approved as the Employer of Record (EOR). If the Enrollee is unable or unwilling to serve as the EOR, another person knowledgeable and involved with the Enrollee's day to day care may be designated. The EOR is responsible for interviewing prospective attendants, meet CDR in the home for all match visits and follow up visits. The EOR is responsible for meeting with the waiver case manager in the home for the initial visit and re-evaluation visit. The EOR should live within fifty (50) miles of participant's home. The EOR must provide weekly supervision. The EOR cannot be the primary contact and cannot be paid for the performing the duties of the Employer of Record.

#### 2.6.8.5. Self-Direction for HCBS Waiver Enrollees

2.6.8.5.1. During Phase III of the transition of HCBS authority (as described in Section 2.5.2 and Appendix C), the CICO will subcontract with SCDHHS's contractor University of South Carolina's Center for Disability Resources (CDR), to ensure waiver Enrollees receive services from qualified attendants and are capable of supervising the care or have someone who can supervise the care on their behalf.

2.6.8.5.2. Once CDR receives an electronic referral from the CICO and determines that self-direction is appropriate, CDR will send an Enrollment packet to the prospective attendant who is then enrolled as a Medicaid Provider. After the prospective attendant meets SCDHHS Provider Enrollment requirements, a CDR nurse will schedule the "match visit" in the Enrollee's home. During the "match visit", the nurse will observe the personal care provided by the individual attendant. Based on this observation, the nurse will provide individualized instruction and training specific to the Enrollee's diagnoses and home environment. CDR staff will also assist with the fiscal agent Enrollment paperwork necessary to establish the employer/employee relationship.

2.6.8.5.3. To facilitate payment, the CICO will utilize SCDHHS's financial management Fiscal Employer Agent, Public Partnership Limited (PPL).

2.6.8.5.4. SCDHHS will assume all administrative costs for both CDR and PPL.

## 2.6.9. Continuity of Care

### 2.6.9.1. Service Transitions

2.6.9.1.1. The CICO shall allow Enrollees receiving any services at the time of Enrollment to maintain their current Providers, including with Providers who are not part of the CICO's network, and service levels, including prescription drugs for at least one hundred eighty (180) days after the Enrollee's Enrollment effective date.

2.6.9.1.2. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 C.F.R. § 438.404 which clearly articulates the Enrollee's right to file an Appeal (either Expedited, if warranted, or standard), the right to have authorized service continue pending the Appeal, and the right to a fair hearing if the CICO renders an adverse determination (either in whole or in part) on the Appeal.

2.6.9.1.3. The CICO is required to maintain current service authorization levels for all direct care waiver services (including personal care, waiver nursing, home care, respite care, community living, adult day health, social work, counseling, independent living assistance, and home delivered meals) during the one hundred eighty day (180) day transition period, unless a significant change has occurred and is documented during the LTC Assessment and/or reassessment.

2.6.9.1.4. Except as provided in Appendix A, all prior approvals for non-Part D drugs, therapies, or other services existing in Medicare or Medicaid at the time of Enrollment will be honored for one hundred eighty (180) calendar days after Enrollment and will not be terminated at the end of one hundred eighty (180) days without advance notice to the Enrollee and transition to other services, if needed.

### 2.6.9.2. Drug Transitions

- 2.6.9.2.1. During the first one hundred eighty (180) days of coverage, the CICO will provide:
  - 2.6.9.2.1.1. A temporary supply of drugs when the Enrollee requests a refill of a non-formulary drug that otherwise meets the definition of a Part D drug; and
  - 2.6.9.2.1.2. A ninety (90) day supply of drugs when an Enrollee requests a refill of a non-Part D drug that is covered by Medicaid.
- 2.6.9.2.2. Part D transition rules and rights will continue as provided for in current law and regulation.
- 2.6.9.2.3. The CICO must provide an appropriate transition process for Enrollees who are prescribed Part D drugs that are not on its formulary (including drugs that are on the CICO's formulary but require prior authorization or step therapy under the CICO's UM rules). This transition process must be consistent with the requirements at 42 C.F.R. § 423.120(b)(3).

2.6.9.3. Provider Transitions

- 2.6.9.3.1. During the one hundred eighty (180) calendar day transition period, the CICO will allow Enrollees to access to any Provider seen by the Enrollee within the previous one-hundred and eighty (180) calendar days prior to transition, even if the Provider is not in the CICO's network.
- 2.6.9.3.2. During the transition period, the CICO will advise Enrollees and Providers if and when they have received care that would not otherwise be covered in-network.
- 2.6.9.3.3. On an ongoing basis, and as appropriate, the CICO must contact Providers who provide services to Enrollees but who are not Network Providers and provide them information on becoming in-Network Providers.



- 2.6.9.3.4. Out-of-network PCPs and specialists providing an ongoing course of treatment must be offered single case agreements to continue to care for the Enrollee beyond the one hundred eighty (180) day transition period if the Provider chooses not to participate in the CICO's network.
- 2.6.9.3.5. The CICO must also offer single-case agreements to Providers to treat the Enrollee until a qualified Network Provider is available. The CICO must offer single case agreements to providers who are:
  - 2.6.9.3.5.1. Not willing to enroll in the CICO's Provider Network, and
  - 2.6.9.3.5.2. Currently serving Enrollees, under the following circumstances:
    - 2.6.9.3.5.2.1. The CICO's network does not have an otherwise qualified Network Provider to provide the services within its Provider Network, or transitioning the care in-house would require the Enrollee to receive services from multiple Providers/facilities in an uncoordinated manner which would significantly impact the Enrollee's condition;
    - 2.6.9.3.5.2.2. Transitioning the Enrollee to another Provider could endanger life, cause suffering or pain, cause undue hardship, physical deformity or malfunction, or significantly disrupt the current course of treatment; or
    - 2.6.9.3.5.2.3. Transitioning the Enrollee to another Provider would require the Enrollee to undertake a substantial change in recommended treatment for Medically Necessary Covered Services.

2.6.9.3.6. If an Enrollee does not identify a current PCP or select a PCP within ninety (90) days of Enrollment, and the CICO has made reasonable, unsuccessful attempts to engage the Enrollee (by phone or by mail) in identifying or selecting a PCP, the CICO shall assign a PCP to the Enrollee and notify the PCP and Enrollee of the assignment. This PCP assignment shall not adversely impact any transition rights that an Enrollee may have.

2.6.9.3.6.1. The CICO must consider the following factors in its assignment of a PCP:

2.6.9.3.6.1.1. Enrollee's ICP;

2.6.9.3.6.1.2. Enrollee preferences;

2.6.9.3.6.1.3. Enrollee's residence and Provider's proximity and/or accessibility;

2.6.9.3.6.1.4. Enrollee acuity and Provider's competency to meet the Enrollee's needs; and

2.6.9.3.6.1.5. Provider's ability to accept new patients.

2.6.9.3.6.2. The Care Coordinator must also make reasonable efforts to not only schedule an appointment for the Enrollee, but also ensure the Enrollee keeps the appointment including by assisting with transportation/escort arrangements if necessary and/or attending the appointment with Enrollee. The CICO may utilize Enrollee incentives to facilitate this occurrence. (see Section 2.12.9.3)

2.6.9.3.6.3. The CICO shall submit a quarterly PCP assignment report that provides the following information: Provider name, NPI Number, number of Enrollees assigned, and practice specialty (e.g., geriatrician, family practitioner with geriatric certification, etc.) and any other specifications determined by SCDHHS.

2.6.9.4. Out of Network Reimbursement Rules

2.6.9.4.1. The CICO must reimburse an out-of-network Provider of emergency or Urgent Care, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, at the Medicare or Medicaid FFS rate applicable for that service. Where this service would traditionally be covered under Medicare FFS, the Medicare FFS rate applies. Enrollees maintain balance billing protections.

2.6.9.4.2. If an Enrollee is receiving any item or service that would not otherwise be covered by the CICO at an in-network level after the continuity of care period, the CICO must notify the Enrollee prior to the end of the continuity of care period, according to the requirements at 42 C.F.R. § 438.404 and 42 C.F.R. § 422.568.

2.6.9.4.2.1. The Enrollee shall be entitled to all Appeal rights, including aid pending Appeal, if applicable, as outlined in Section 2.11 of this Contract.

#### 2.6.9.5. Transferring Service Plans and Liabilities

2.6.9.5.1. The CICO must be able to accept and honor established Waiver Service Plans documented in Phoenix from FFS when Enrollees transition with Waiver Service Plans in place; and

2.6.9.5.2. The CICO must be able to ensure timely transfer of ICPs to other CICOs or other plans when an Enrollee is disenrolling from the CICO. The Waiver Service Plan when appropriate will be available to the transferring CICO via Phoenix.

2.6.9.5.3. If an Enrollee is receiving medical care or treatment as an inpatient in an acute care hospital at the time coverage under this Contract is terminated, the CICO shall arrange for the continuity of care or treatment for the current episode of illness until such medical care or treatment has been fully transferred to a treating Provider who has agreed to assume responsibility for such medical care or treatment for the remainder of that hospital episode and subsequent follow-up care. The CICO must maintain documentation of such transfer of responsibility of medical care or treatment. For hospital stays that would otherwise be reimbursed under Medicare or the South Carolina State Medicaid Program on a per diem basis, the CICO shall be liable for payment for any medical care or treatment provided to an Enrollee until the effective date of disenrollment. For hospital stays that would otherwise be reimbursed under Medicare or the South Carolina State Medicaid Program on a diagnosis-related group (DRG) basis, the CICO shall be liable for payment for any inpatient medical care or treatment provided to an Enrollee where the discharge date is after the effective date of disenrollment.

2.6.9.6. Transitions Prior to the End of the 180-day Transition Period

2.6.9.6.1. CICOs may choose to transition Enrollees to a network PCP earlier than one hundred eighty (180) days only if all the following criteria are met:

- 2.6.9.6.1.1. The Enrollee is assigned to a Medical Home that is capable of serving his/her needs appropriately;
- 2.6.9.6.1.2. The CICO has completed a Comprehensive Assessment for the Enrollee;
- 2.6.9.6.1.3. The CICO consulted with the new Medical Home and determined that the Medical Home is accessible, competent, and can appropriately meet the Enrollee's needs;
- 2.6.9.6.1.4. A transition care plan is in place (to be updated and agreed to with the new PCP, as necessary); and

- 2.6.9.6.1.5. The Enrollee agrees to the transition and transition plan prior to the expiration of the one hundred eighty (180) day transition period.
- 2.6.9.6.2. The CICO may choose to transition Enrollees to a network specialist or LTSS Provider earlier than one hundred eighty (180) calendar days only if all the following criteria are met:
  - 2.6.9.6.2.1. A Comprehensive Assessment is complete;
  - 2.6.9.6.2.2. A transition care plan is in place (to be updated and agreed to with the new Provider, as necessary); and
  - 2.6.9.6.2.3. The Enrollee agrees to the transition and plan prior to the expiration of the one hundred eighty (180) day transition period.
- 2.6.9.7. Transition Planning Participation
  - 2.6.9.7.1. The CICO shall implement policies and procedures that (1) ensure timely and effective treatment and transition planning; (2) establish the associated documentation standards; (3) involve the Enrollee and the appropriate facility staff; and (4) begin the transition planning process on day of admission to the facility or the day of presentation to the emergency department. Treatment and transition planning shall include at least:
    - 2.6.9.7.1.1. When possible, establishment of transition planning protocols with Network Providers, taking into consideration the model of care transition planning utilized by Providers, especially hospitals. Protocols should include identification of single point of contact for the clinical follow up call once the Enrollee is transitioned;
    - 2.6.9.7.1.2. Identification and assignment of a facility-based care manager for the Enrollee. This staff member shall be involved in the establishment and implementation of treatment and transition planning;

- 2.6.9.7.1.3. Notification and participation of Enrollee's MT, including the PCP, in transition planning, coordination, and re-assessment, as needed;
- 2.6.9.7.1.4. Collaboration with facility staff and/or Home Again transition coordinators to ensure appropriate and safe transition;
- 2.6.9.7.1.5. In coordination with the facility, identification of clinical and non-clinical supports as well as the role they serve in an Enrollee's treatment and aftercare plans;
- 2.6.9.7.1.6. Scheduling of transition/aftercare appointments in accordance with the access and availability standards;
- 2.6.9.7.1.7. Identification of barriers to aftercare, and the strategies developed to address such barriers;
- 2.6.9.7.1.8. Assurance that inpatient and twenty-four (24) hour diversionary behavioral health Providers provide a transition plan to the MT following any behavioral health admission;
- 2.6.9.7.1.9. Conducting clinical follow up phone call or home visit within seventy-two (72) hours of transition. This process should involve documented discussions with the Enrollee and/or designee related to:
  - 2.6.9.7.1.9.1. Medication reconciliation and medication management;
  - 2.6.9.7.1.9.2. Comprehension of and compliance with other components of discharge or transition orders; and
  - 2.6.9.7.1.9.3. The coordination and dissemination of documented discussions and other knowledge obtained with the entire transition care team (i.e., PCP, facility staff).
- 2.6.9.7.1.10. Medication monitoring and adherence using evidence-based protocols, as clinically necessary; and,

2.6.9.7.1.11. Document all efforts related to these activities, including the Enrollee's active participation in transition planning.

## 2.6.10. Reporting of Serious Reportable Events

2.6.10.1. The CICO must document all Serious Reportable Events within Phoenix.

2.6.10.2. Serious Reportable Events include but are not limited to:

2.6.10.2.1. Deaths (unexpected, suicide, or homicide);

2.6.10.2.2. Falls (resulting in death, injury requiring hospitalization, injury that will result in permanent loss of function);

2.6.10.2.3. Infectious disease outbreaks;

2.6.10.2.4. Pressure ulcers that are unstageable or are Staged III and IV;

2.6.10.2.5. Traumatic injuries (including third degree burns over more than ten (10%) percent of the body) that result in death, require hospitalization, or result in a loss of function;

2.6.10.2.6. Restraints, both chemical and physical, use that results in death, hospitalization, or loss of function;

2.6.10.2.7. All elopements in which an Enrollee with a documented cognitive deficit is missing for twenty-four (24) hours or more;

2.6.10.2.8. Suspected physical, mental or sexual abuse and/or neglect; and

2.6.10.2.9. Media-related event. Any report of which the CICO is aware that presents a potential or harmful characterization of the CICO or Demonstration.

## 2.7. Provider Network

### 2.7.1. Network Adequacy

2.7.1.1. The CICO must maintain a Provider Network sufficient to provide all Enrollees with access to the full range of Covered Services, including

the appropriate range of preventive, primary care, and specialty services, behavioral health services, other specialty services, and all other services required in 42 C.F.R. §§422.112, 423.120, and 438.206, and under this Contract (see Covered Services in Appendix A), taking into consideration:

- 2.7.1.1.1. The anticipated number of Enrollees;
  - 2.7.1.1.2. The expected utilization of services, in light of the characteristics and health care needs of the CICO's Enrollees;
  - 2.7.1.1.3. The number and types (in terms of training, experience, and specialization) of Providers required to furnish the Covered Services;
  - 2.7.1.1.4. The number of Network Providers who are not accepting new patients;
  - 2.7.1.1.5. The geographic location of Providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities;
  - 2.7.1.1.6. The communication needs of Enrollees; and.
  - 2.7.1.1.7. The cultural and ethnic diversity and demographic characteristics of Enrollees.
- 2.7.1.2. The CICO must demonstrate annually that its Provider Network meets the stricter of the following standards:
- 2.7.1.2.1. For Medicare medical Providers and facilities, time, distance and minimum number standards updated annually on the CMS website (<http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/index.html>);
  - 2.7.1.2.2. For Medicare pharmacy Providers, time, distance and minimum number as required in Appendix E, Article II, Section I and 42 C.F.R. § 423.120; or



- 2.7.1.2.3. For services in which Medicaid is the traditional primary payor, including behavioral health and substance abuse services, the CICO must establish a Provider Network that meets the existing requirements of the Medicaid Managed Care program, as dictated by the [Medicaid Managed Care Contract, and Policy and Procedures Guide](#) (available at <https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp>).
- 2.7.1.2.4. For CICO behavioral health Providers who provide only Medicaid-covered services, the CICO must contract with at least two (2) Providers located no more than fifty (50) miles from any Enrollee unless the CICO has an SCDHHS-approved alternative time standard.
  - 2.7.1.2.4.1. At least one of the behavioral health Providers used to meet the two (2) Providers per fifty (50) mile requirement must be a Community Mental Health Center (CMHC).
- 2.7.1.2.5. For Providers of overlap services that may be subject to either Medicaid or Medicare network requirements, the stricter of any applicable standards will apply.
- 2.7.1.3. The CICO's network shall also meet the following access to care requirements:
  - 2.7.1.3.1. For the first year of the Demonstration, facility-based LTSS must meet Medicare network standards for skilled nursing facilities.
  - 2.7.1.3.2. Through Phase II of the HCBS transition, the CICO must extend contracts to every willing HCBS Provider that currently provides services to the Demonstration targeted population, as identified by SCDHHS.
- 2.7.1.4. If the CICO's Provider Network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the CICO must adequately and timely cover these services out of network for the Enrollee, for as long as the CICO is unable to provide the services in network.
- 2.7.1.5. The CICO must notify the CMT of any significant Provider Network changes immediately, but no later than five (5) business days after becoming aware of an issue, including a change in the CICO's Provider Network that renders the CICO unable to provide one (1) or

more covered items and services within the access to care standards set forth in this section, with the goal of providing notice to the CMT at least sixty (60) days prior to the effective date of any such change.

- 2.7.1.6. Enrollees must be assured choice of all Providers.
  - 2.7.1.7. SCDHHS and CMS will monitor access to care and the prevalence of needs indicated through Enrollee Comprehensive Assessments, and, based on those findings, may require that the CICO initiate further Provider Network expansion over the course of the Demonstration.
  - 2.7.1.8. The CICO shall establish mechanisms to ensure timely access to care by all Providers;
  - 2.7.1.9. The CICO shall monitor all Providers regularly to determine compliance;
  - 2.7.1.10. The CICO will take corrective action if there is a failure to comply with timely access to care by any Provider; and
  - 2.7.1.11. The CICO shall ensure that Enrollees have access to the most current and accurate information by updating its online Provider directory and search functionality on a timely basis. This information includes Provider compliance with the ADA in terms of physical and communications accessibility for Enrollees who are blind or deaf as well as other reasonable accommodations.
- 2.7.2. Network Provider Requirements
- 2.7.2.1. All Network Providers must serve the target population.
  - 2.7.2.2. All Providers' physical sites must be accessible to all Enrollees, as must all Providers that deliver services in the Enrollees' locations.
  - 2.7.2.3. The CICO shall ensure that its Network Providers are responsive to the linguistic, cultural, ethnic, racial, religious, age, gender and other unique needs of any minority, homeless population, Enrollees with disabilities (both congenital and acquired disabilities), or other special population served by the CICO. This responsiveness includes the capacity to communicate with Enrollees in languages other than English, when necessary, as well as those with a vision or hearing impairment.
  - 2.7.2.4. The CICO shall ensure that multilingual Network Providers and, to the extent that such capacity exists within the CICO's Service Area, all Network Providers, understand and comply with their obligations under state or federal law to assist Enrollees with skilled medical

interpreters and the resources that are available to assist Network Providers to meet these obligations.

- 2.7.2.5. The CICO shall ensure that Network Providers and interpreters/translators are available for those within the CICO's Service Area who are deaf, or vision- or hearing-impaired.
- 2.7.2.6. The CICO shall ensure that its Network Providers have a strong understanding of disability, recovery, and resilience cultures and LTSS.
- 2.7.2.7. The CICO shall make best efforts to ensure that minority-owned or controlled agencies and organizations are represented in the Provider Network.
- 2.7.2.8. Network Provider Enrollment. CICO shall assure that all Network Providers that provide Medicare Covered Services are enrolled as Medicare Providers in order to submit claims for reimbursement or otherwise participate in the Medicare Program. CICO shall assure that all Network Providers, including out-of-state Network Providers, that provide Medicaid Covered Services are enrolled in the South Carolina Medicaid Program, if such enrollment is required by SCDHHS's rules or policy in order to submit claims for reimbursement or otherwise participate in the South Carolina Medicaid Program.
- 2.7.2.9. The CICO shall ensure that the Provider Network provides female Enrollees with direct access to a women's health specialist, including a gynecologist, within the Provider Network for Covered Services necessary to provide women's routine and preventive health care services. This shall include contracting with, and offering to female Enrollees, women's health specialists as PCPs.
- 2.7.2.10. Nursing facility Providers are not required to participate in the Medicaid program; however, they must be certified as a skilled nursing facility under the Medicare program. The CICO is not required to continue contracting with nursing facilities that fail to meet its minimum quality standards for participation in the Demonstration. Other policies and procedures of participation will be addressed by the state prior to January 1, 2015, implementation in conjunction with the Nursing Facility Workgroup and documented in both the Nursing Facility Provider Manual and the [Medicaid Managed Care Policy and Procedures Guide](https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp) (<https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp>).
- 2.7.2.11. Second Opinions

2.7.2.11.1. At the Enrollee's request, the CICO shall provide for a second opinion from a qualified health care professional within the Provider Network, or arrange for the Enrollee to obtain a second opinion outside the Provider Network, at no cost to the Enrollee.

### 2.7.3. Provider Contracting

2.7.3.1. The CICO must contract only with qualified or licensed Providers who continually meet federal and state requirements, as applicable, and the qualifications contained in Appendix E.

2.7.3.2. The CICO shall not establish selection policies and procedures for Providers that discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

2.7.3.3. Paid family caregivers will be permitted in accordance with the Self-Directed Care Provision, Medicaid Policy Regarding Relatives Serving as Paid Caregivers, 2004 found in the CLTC Policy and Procedure Manual at <https://phoenix.scdhhs.gov/policy>.

2.7.3.4. If the CICO declines to include individuals or groups of Providers in its Provider Network, the CICO must give the affected Providers written notice of the reason for its decision.

2.7.3.5. For HCBS, during the first year of the demonstration, and through Phase II of the HCBS transition plan, the CICO must extend contracts to every willing provider that currently serves Eligible Beneficiaries receiving HCBS, as identified by SCDHHS. SCDHHS will establish additional contract parameters for future years, including minimum reimbursement requirements, during the first contract year and will release those to the CICOs in separate guidance.

2.7.3.5.1. Beginning in Phase III of the HCBS transition plan, the CICO may establish quality standards and may terminate a contract of a Provider based on a failure to meet such quality standards. SCDHHS may grant exceptions to these contracting requirements for reasons other than failure to meet the quality standards. The CICOs must transition Enrollees, or have a plan to transition Enrollees, to new Providers prior to terminating contracts with Providers.

2.7.3.6. Excluded Providers

- 2.7.3.6.1. The CICO may not contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a Provider that has been excluded from participation in federal health care programs by the OIG of the U.S. Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, and implementing regulations at 42 C.F.R. Part 1001 et. seq., or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. §1001.1801 and §1001.1901;
- 2.7.3.6.2. The CICO shall, at a minimum, check the SCDHHS website at least once per month for a list of South Carolina Medicaid excluded providers ([http://www.scdhhs.gov/internet/pdf/Exclusion\\_Provider\\_List\\_for\\_DHHS\\_Website.xls](http://www.scdhhs.gov/internet/pdf/Exclusion_Provider_List_for_DHHS_Website.xls));
- 2.7.3.6.3. The CICO shall, at a minimum, check the OIG List of Excluded Individuals Entities (LEIE), Medicare Exclusion Database (MED), and the System for Awards Management (SAM) (the successor to the Excluded Parties List System (EPLS)) for its Providers at least monthly, before contracting with the Provider, and at the time of a Provider's credentialing and recredentialing.
- 2.7.3.6.4. If a Provider is terminated or suspended from the SCDHHS Medicaid Program, Medicare, or another state's Medicaid program or is the subject of a state or federal licensing action, the CICO shall terminate, suspend, or decline a Provider from its Provider Network as appropriate.
- 2.7.3.6.5. Upon notice from SCDHHS or CMS, not authorize any Providers who are terminated or suspended from participation in the South Carolina Medicaid Program, Medicare, or from another state's Medicaid program, to treat Enrollees and shall deny payment to such Providers for services provided.
- 2.7.3.6.6. The CICO shall notify CMS and SCDHHS, via the CMT, when it terminates, suspends, or declines a Provider from its Provider Network because of Fraud, integrity, or quality;

2.7.3.6.7. The CICO shall notify CMS and SCDHHS on a quarterly basis when a Provider fails credentialing or re-credentialing because of a program integrity or adverse action reason, and shall provide related and relevant information to CMS and SCDHHS as required by CMS, SCDHHS, or state or federal laws, rules, or regulations.

2.7.3.7. Primary Care Provider Qualifications

2.7.3.7.1. For purposes of establishing the Provider Network, a PCP must be:

2.7.3.7.1.1. A Physician who is:

2.7.3.7.1.1.1. Licensed by the State of South Carolina;

2.7.3.7.1.1.2. Specialized in family practice, internal medicine, general practice, OB/GYN, or geriatrics; or

2.7.3.7.1.1.3. A specialist who performs primary care functions including but not limited to, federally qualified health centers, rural health clinics, health departments and other similar community clinics; and

2.7.3.7.1.1.4. In good standing with the Medicare and Medicaid programs.

2.7.3.7.1.2. A registered nurse or nurse practitioner who is licensed by the State of South Carolina; or

2.7.3.7.1.3. A physician assistant who is licensed by the State of South Carolina.

2.7.3.7.2. For purposes of providing clinical care, a Medical Home may identify a nurse practitioner, who is licensed by the State of South Carolina, as a PCP for an Enrollee.

2.7.3.8. Behavioral Health Providers

2.7.3.8.1. In addition to those requirements described above, the CICO shall comply with the requirements of 42 C.F.R. § 438.214 regarding selection, retention and exclusion of behavioral health Providers. The CICO shall have an adequate network of behavioral health and substance abuse Providers to meet the needs of the population, including their community mental health rehabilitative service needs. Examples of these types of Providers include, but are not limited to, inpatient psychiatric hospitals, community mental health centers, psychiatrists, clinical psychologists, licensed independent social workers, marriage and family therapists, licensed counselors, and outpatient substance abuse treatment providers.

2.7.3.9. Providers of Medicaid covered behavioral health services must have the appropriate licensure and qualifications as outlined in the South Carolina Rehabilitative Behavioral Health Services Provider Manual. (<https://www.scdhhs.gov/provider-type/rhc-behavioral-health-services-april-1-2012-edition-posted-051812>)

#### 2.7.4. Indian Health Network

2.7.4.1. The CICO must demonstrate that it made reasonable efforts to contract with Indian health care Providers; Indian Health Service (IHS); an Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) Providers in the network to ensure timely access to services available under the contract for Indian Enrollees who are eligible to receive services from such Providers.

2.7.4.1.1. The CICO shall offer Indian Enrollees the option to choose an Indian health care provider as a PCP if the CICO has an Indian PCP in its network that has capacity to provide such services;

2.7.4.1.2. The CICO shall demonstrate that it has sufficient access to Indian Health Care Providers to ensure access to Covered Services for Indian Enrollees;

- 2.7.4.1.3. The CICO shall pay both network and non-network Indian Health Care Providers who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the SCDHHS fee for service rate for the same service or, in the absence of a negotiated rate, an amount not less than the amount that the CICO would pay for the Covered Service provided by a non-Indian Health Care Provider;
  - 2.7.4.1.4. The CICO shall make prompt payment to Indian Health Care Providers; and
  - 2.7.4.1.5. The CICO shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the CICO would pay to a network FQHC that is not an Indian Health Care Provider.
  - 2.7.4.1.6. The CICO must permit any Indian who is enrolled in a non-Indian Demonstration and eligible to receive services from a participating Indian health care Provider; IHS; and I/T/U Provider, to choose to receive Covered Services from that I/T/U provider, and if that I/T/U provider participates in the network as a PCP, to choose that I/T/U as his or her PCP, as long as that Provider has capacity to provide the services.
- 2.7.4.2. Non-Allowed Terms of Provider Contracts
- 2.7.4.2.1. The CICO shall not require as a condition of participation/contracting with Providers in their CICO network to also participate in the CICO's other lines of business (e.g., commercial managed care network). However, this provision would not preclude a CICO from requiring their commercial network providers to participate in their CICO Provider Network.
  - 2.7.4.2.2. The CICO shall not require as a condition of participation/contracting with Providers in the network a Provider's terms of panel participation with other CICOs.



2.7.4.2.3. The CICO shall not include in its Provider Contracts any provision that directly or indirectly prohibits, through incentives or other means, limits, or discourages Network Providers from participating as Network or non-network Providers in any Provider Network other than the CICO's Provider Network(s).

## 2.7.5. Provider Credentialing, Recredentialing, and Board Certification

- 2.7.5.1. The CICO shall implement written policies and procedures that comply with the requirements of 42 C.F.R. §§422.504(i)(4)(iv) and 438.214(b) regarding the selection, retention and exclusion of Providers, credentialing and recredentialing requirements and nondiscrimination, and meet, at a minimum, the requirements below.
- 2.7.5.2. The CICO shall credential Providers, except as provided in Section 2.8.8, in accordance with National Committee for Quality Assurance (NCQA) credentialing standards (<http://www.ncqa.org/Programs/Certification/UtilizationManagementandCredentialingUMCR/OCProgramEvaluationOptions/CRStandardsandGuidelines.aspx>) as well as applicable state and federal requirements.
- 2.7.5.3. Re-credentialing shall occur every thirty-six (36) months. At re-credentialing and on a continuing basis, the CICO shall verify minimum credentialing requirements and monitor Enrollee Complaints and Appeals, quality of care and quality of service events, and medical record review. The recredentialing process shall take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews UM information, and Enrollee satisfaction surveys.
- 2.7.5.4. The CICO's standards for licensure and certification shall be outlined in the Provider manual or included in its participating Provider Network contracts with its Network Providers which must be secured by current subcontracts or employment contracts.
- 2.7.5.5. The CICO shall ensure that all Providers are credentialed prior to becoming Network Providers and that a site visit is conducted as appropriate for initial credentialing;
- 2.7.5.6. The CICO shall not establish Provider selection policies and procedures that discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment;
- 2.7.5.7. The CICO shall ensure that no credentialed Provider engages in any practice with respect to any Enrollee that constitutes unlawful

discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90;

- 2.7.5.8. The CICO shall obtain disclosures from all Network Providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R. § 1002.3, including, but not limited to, obtaining such information through Provider Enrollment forms and credentialing and recredentialing packages, and maintain such disclosed information in a manner which can be periodically searched by the CICO for exclusions and provided to SCDHHS in accordance with this Contract, including this Section, and relevant state and federal laws and regulations; and
- 2.7.5.9. Include the consideration of performance indicators obtained through the quality improvement plan (QIP), UM program, Grievance and Appeals system, and Enrollee satisfaction surveys in the CICO's recredentialing process.
- 2.7.5.10. The CICO shall submit its written policies and procedures annually to SCDHHS, if amended, and shall demonstrate to SCDHHS, by reporting annually, that all providers within the CICO's Provider and Pharmacy Network are credentialed according to such policies and procedures. The CICO shall maintain written policies that:
  - 2.7.5.10.1. Designate and describe the department(s) and person(s) at the CICO's organization who will be responsible for Provider credentialing and re-credentialing;
  - 2.7.5.10.2. Document the processes for the credentialing and re-credentialing of licensed physician Providers and all other licensed or certified Providers who participate in the CICO's Provider Network to perform the services agreed to under this contract. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations. Standards of participation in the state's HCBS waiver programs are outlined in the scope of services for each Provider type and can be found at <https://www.scdhhs.gov/historic/insideDHHS/Bureaus/BureauofLongTermCareServices/BECOMINGAcltcPROVIDER.html>
- 2.7.5.11. Board Certification Requirements

2.7.5.11.1. The CICO shall maintain a policy with respect to board certification for PCPs and specialty Providers participating in the Provider Network.

## 2.7.6. Provider Payment and Reimbursement

2.7.6.1. The CICO must demonstrate to SCDHHS, including through submission of reports as may be requested by SCDHHS, use of value-oriented payment methodologies (VOPMs). VOPMs are payments designed to reflect value and are tied to provider performance that may rise or fall in a predetermined fashion commensurate with different levels of performance. Notwithstanding the foregoing, nothing herein shall be construed to conflict with the requirements of 42 U.S.C. 1395w-111.

2.7.6.1.1. VOPMs may include but not be limited to the following:

2.7.6.1.1.1. Pay Providers differentially according to performance (and reinforce with benefit design).

2.7.6.1.1.2. Design approaches to payment that cut waste while not diminishing quality, including reducing unwarranted payment variation.

2.7.6.1.1.3. Design payments to encourage adherence to clinical guidelines.

2.7.6.1.2. Targets for VOPMs must align with the Medicaid Managed Care Contract requirements, beginning with CY 2015.

2.7.6.1.2.1. Contractor Targets for Value-Based Purchasing by calendar year:

2.7.6.1.2.1.1. Year 1 (2015): 5 percent of total payment

2.7.6.1.2.1.2. Year 2 (2016): 12 percent of total payment

2.7.6.1.2.1.3. Year 3 (2017): 20 percent of total payment

2.7.6.1.2.2. Total payment represents total capitation payments made to the CICO.

2.7.6.1.3. Reporting on VOPMs will be in accordance with the Managed Care Policy and Procedure Manual.

- 2.7.6.1.4. The CICO must include shared savings program for both community based and facility based LTSS providers.
- 2.7.6.2. For items and services that are part of the traditional Medicare benefit package, the CICO will be required to pay non-contracting Providers at least the lesser of the Providers' charges or the Medicare FFS rate, regardless of the setting and type of care for authorized out-of-network services.
- 2.7.6.3. FQHCs Reimbursements
  - 2.7.6.3.1. The CICO shall ensure that its payments to FQHCs for services to Enrollees are no less than the sum of:
    - 2.7.6.3.1.1. The level and amount of payment that the CICO would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC, and
    - 2.7.6.3.1.2. The amount that South Carolina Medicaid would have paid in cost sharing if the Enrollee were in FFS.
- 2.7.6.4. Out of Network Reimbursement Rules
  - 2.7.6.4.1. The CICO must reimburse an out-of-network Provider of emergent or Urgent Care, as defined by 42 C.F.R. § 424.101 and 42 C.F.R. § 405.400 respectively, at the prevailing Medicare or Medicaid FFS payment levels for that service.
  - 2.7.6.4.2. The CICO may authorize other out-of-network services to promote access to and continuity of care. For services that are part of the traditional Medicare benefit package, prevailing Medicare Advantage policy will apply, under which CICOs shall pay out-of-network Providers the amount that would have been paid by Medicare and/or SCDHHS if the Enrollee was not enrolled in the Demonstration, but rather enrolled in Medicare and SCDHHS's Medicaid program, regardless of the setting and type of care for authorized out-of-network services.
- 2.7.6.5. Primary Care Payment Rates

2.7.6.5.1. As directed by SCDHHS, the CICO shall set payment rates for primary care services provided by eligible Providers in accordance with Section 1202 of the ACA and 42 U.S.C. § 1396a(a)(13)(C), and all applicable federal and state laws, regulations, rules, and policies related to the implementation of such requirement. Notwithstanding the generality of the foregoing, the CICO shall, in accordance with 42 C.F.R. § 438.6(c)(5)(vi), for payments for primary care services in calendar year 2014 furnished to Enrollees under 42 C.F.R. Part 447, subpart G:

2.7.6.5.1.1. Make payments to those specified physicians (whether directly or through a capitated arrangement) at least equal to the amounts set forth and required under 42 C.F.R. Part 447, subpart G; and

2.7.6.5.1.2. Provide documentation to the SCDHHS, sufficient to enable SCDHHS to ensure that Provider payments are made as required by this Section 2.7.5.

2.7.6.6. Non-Payment and Reporting of Provider Preventable Conditions

2.7.6.6.1. The CICO agrees to take such action as is necessary in order for SCDHHS to comply with and implement all federal and state laws, regulations, policy guidance, and South Carolina policies and procedures relating to the identification, reporting, and non-payment of Provider Preventable Conditions, as defined in 42 U.S.C. 1396b-1 and regulations promulgated thereunder.

2.7.6.6.2. As a condition of payment, the CICO shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including, but not limited to, 42 C.F.R. §§ 434.6(a)(12), 438.6(f)(2), and 447.26, and guidance and be consistent with SCDHHS policies, procedures, and guidance on Provider Preventable Conditions.

2.7.6.6.3. The CICO's policies and procedures shall also be consistent with the following:

- 2.7.6.6.3.1. The CICO shall not pay a Provider for a Provider Preventable Condition.
- 2.7.6.6.3.2. The CICO shall require, as a condition of payment from the CICO, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the CICO and/or SCDHHS.
- 2.7.6.6.3.3. The CICO shall not impose any reduction in payment for a Provider-Preventable Condition when the condition defined as a Provider-Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee.
- 2.7.6.6.3.4. A CICO may limit reductions in Provider payments to the extent that the following apply:
  - 2.7.6.6.3.4.1. The identified Provider-Preventable Condition would otherwise result in an increase in payment;
  - 2.7.6.6.3.4.2. The CICO can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider-Preventable Condition;
- 2.7.6.6.3.5. The CICO shall ensure that its non-payment for Provider-Preventable Conditions does not prevent Enrollee access to services;
- 2.7.6.6.3.6. As directed by SCDHHS, and in consultation with CMS, the CICO shall develop and implement process for ensuring non-payment or recovery of payment for preventable hospital readmissions; and
- 2.7.6.6.3.7. The CICO shall report all identified Provider-Preventable Conditions in a form and format specified by SCDHHS within seven (7) calendar days from occurrence.

## 2.7.6.7. Incentive Payments

#### 2.7.6.7.1. Nursing Facility Transitions

- 2.7.6.7.1.1. Any Enrollee residing in a nursing facility with a combined ninety (90) consecutive days of hospital and Medicaid skilled nursing placement may qualify for the Home Again based on the program's eligibility and intake criteria. Upon transition, eligible Enrollees must enter one of the three (3) waivers included in the Demonstration. Once eligible Enrollees return to the community, the CICO must offer them any enhanced home and community based services covered through the Home Again program.
- 2.7.6.7.1.2. Qualifying CICOs may receive up to three thousand dollars (\$3,000) for providing enhanced transition coordination services for successfully de-institutionalizing an eligible Enrollee for at least twelve (12) months as outlined in the Transition Coordination Scope of Service for the Home Again program. The CICO's Care Coordinators are responsible for assessing an Enrollee's interest in and potential for making the transition. The Care Coordinator also develops a transition plan and continues intensive care coordination through the end of the transition period (12-months).

#### 2.7.6.7.2. Patient – Centered Medical Homes

- 2.7.6.7.2.1. Patient Centered Medical Home Recognition Program: The CICO will facilitate the development of Patient Centered Medical Home (PCMH) model as defined through the certification process through the NCQA, or other PCMH recognition bodies that SCDHHS deems credible (e.g., Joint Commission on Accreditation of Healthcare Organizations). As part of that, the CICO will provide financial incentives to qualified Providers that achieve NCQA PCMH certification. SCDHHS will make incentive payments to both the CICO and eligible Providers (to be administered by the CICO) for achieving various levels of NCQA certification and FQHCs who achieve JCAHO PCMH recognition.

2.7.6.7.2.2. Quarterly PMPM payments will be made to both the CICO and Providers according to the provisions found within the Policies and Procedures Guide (May 2014) of the current SCDHHS Managed Care contract (<https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp>).

2.7.6.7.3. Physician Plans

2.7.6.7.3.1. The CICO may, in its discretion, operate a physician incentive plan only if:

2.7.6.7.3.1.1. No single physician is put at financial risk for the costs of treating an Enrollee that is outside the physician's direct control;

2.7.6.7.3.1.2. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically appropriate services furnished to an individual Enrollee; and

2.7.6.7.3.1.3. The applicable stop/loss protection, Enrollee survey, and disclosure requirements of 42 C.F.R. Part 417 are met.

2.7.6.7.3.2. The CICO and its First Tier, Downstream and Related Entities must comply with all applicable requirements governing physician incentive plans, including, but not limited to, such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438.6(h), and 1003. The CICO must submit all information required to be disclosed to CMS and SCDHHS in the manner and format specified by CMS and SCDHHS which, subject to federal approval, must be consistent with the format required by CMS for Medicare contracts.



2.7.6.7.3.3. The CICO shall be liable for any and all loss of federal financial participation (FFP) incurred by SCDHHS that results from the CICO's or its subcontractors' failure to comply with the requirements governing physician incentive plans at 42 C.F.R. Parts 417, 434 and 1003; however, the CICO shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the CICO's plan, and the CICO shall not be liable if it can demonstrate, to the satisfaction of CMS and SCDHHS, that it has made a good faith effort to comply with the cited requirements.

## 2.7.7. Network Management

2.7.7.1. The CICO shall develop and implement a strategy to manage the Provider Network with a focus on access to services for Enrollees, quality, consistent practice patterns, recovery and resilience, Independent Living Philosophy, cultural competence, integration and cost effectiveness. The management strategy shall address all Providers. At a minimum, such strategy shall include:

2.7.7.1.1. A system for the CICO and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward those improvement goals;

2.7.7.1.2. Conducting on-site visits to Network Providers for quality management and quality improvement purposes, and for assessing meaningful compliance with ADA requirements; and

2.7.7.1.3. Ensuring that its Provider Network is adequate to assure access to all Covered Services, and that all providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the Covered Services;

2.7.7.2. CICO shall make a good faith effort to give written notice of termination of a Provider (medical, behavioral health, or LTSS) as soon as practicable, but in no event later than fifteen (15) calendar days following the receipt or issuance of such termination notice, to each Enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated Provider. The CICO shall also assist Enrollees in transitioning to a new Provider, when a Provider's

contract is terminated. For terminations of PCPs, the CICO must also report the termination to SCDHHS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days.

- 2.7.7.3. The CICO shall not limit or prohibit Provider-based marketing activities or Provider affiliation information addressed by §§ 70.11.1 and 70.11.2 of the Medicare Marketing Guidelines. The CICO shall not prohibit a Provider from informing Enrollees of the Provider's affiliation or change in affiliation.
- 2.7.7.4. The CICO shall establish and conduct an ongoing process for enrolling in their Provider Network willing and qualified Providers who meet the CICO's requirements and with whom mutually acceptable Provider Contract terms, including with respect to rates, are reached.
- 2.7.7.5. The CICO shall maintain a protocol that shall facilitate communication to and from Providers and the CICO, and which shall include, but not be limited to, a Provider newsletter and periodic Provider meetings;
- 2.7.7.6. Except as otherwise required or authorized by CMS, SCDHHS, or by operation of law, the CICO shall ensure that Providers receive thirty (30) days advance notice in writing of policy and procedure changes, and maintain a process to provide education and training for Providers regarding any changes that may be implemented, prior to the policy and procedure changes taking effect; and
- 2.7.7.7. The CICO shall work in collaboration with Providers to actively improve the quality of care provided to Enrollees, consistent with the Quality Improvement Strategic Workplan and all other requirements of this Contract.
- 2.7.7.8. The CICO shall perform an annual review to assure that the health care professionals under contract with the First Tier, Downstream, and Related Entities are qualified to perform the services covered under this Contract. The CICO must have in place a mechanism for reporting to the appropriate authorities any actions that seriously impact quality of care and which may result in suspension or termination of a Provider's license.
- 2.7.7.9. The CICO shall require its Providers to fully comply with federal requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against federal related health care programs, including Medicare, Medicaid, and/or CHIP programs, as described in 42 C.F.R. § 455.
- 2.7.7.10. The CICO shall collect sufficient information from Network Providers to ensure their compliance with the ADA.

## 2.7.8. Provider Education and Training

- 2.7.8.1. Prior to any Enrollment of Enrollees under this Contract and thereafter, the CICO shall conduct Network Provider education regarding the CICO's policies and procedures as well as the Demonstration.
- 2.7.8.2. The CICO must educate its Provider Network about its responsibilities for the integration and coordination of Covered Services;
- 2.7.8.3. The CICO must inform its Provider Network about its policies and procedures, especially regarding in and out-of-network referrals;
- 2.7.8.4. The CICO must inform its Provider Network about its service delivery model and Covered Services, flexible benefits, excluded services (carved-out) and, policies, procedures, and any modifications to these items;
- 2.7.8.5. The CICO must inform its Provider Network about the procedures and timeframes for Enrollee Complaints and Enrollee Appeals, per 42 C.F.R. §438.414;
- 2.7.8.6. The CICO must inform its Provider Network about its quality improvement efforts and the Providers' role in such a program;
- 2.7.8.7. The CICO shall educate Network Providers about the Medical Home model and the importance of using it to integrate all aspects of each Enrollee's care, as well as how to become a Medical Home.
- 2.7.8.8. The CICO must ensure that all Network Providers receive proper education and training regarding the Demonstration to comply with this Contract and all applicable federal and state requirements. The CICO shall offer educational and training programs that cover topics or issues including, but not limited to, the following:
  - 2.7.8.8.1. Eligibility standards, eligibility verification, and benefits;
  - 2.7.8.8.2. The role of SCDHHS (or its authorized agent) regarding Enrollment and disenrollment;
  - 2.7.8.8.3. Special needs of Enrollees that may affect access to and delivery of services, to include, at a minimum, transportation needs;
  - 2.7.8.8.4. ADA compliance, accessibility and accommodations;

- 2.7.8.8.5. The rights and responsibilities pertaining to
    - 2.7.8.8.5.1. Grievance and Appeals procedures and timelines; and
    - 2.7.8.8.5.2. Procedures for identifying, preventing and reporting Fraud, waste, neglect, abuse, exploitation, and critical incidents;
  - 2.7.8.8.6. References to Medicaid and Medicare manuals, memoranda, and other related documents;
  - 2.7.8.8.7. Payment policies and procedures including information on no balance billing;
  - 2.7.8.8.8. PCP training on identification of and coordination of LTSS and behavioral health services;
  - 2.7.8.8.9. Cultural competencies;
  - 2.7.8.8.10. Person-centered planning processes taking into consideration the specific needs of subpopulations of Enrollees;
  - 2.7.8.8.11. Advanced directives and the provisions of the Patient Self-Determination Act of 1990;
  - 2.7.8.8.12. Billing instructions which are in compliance with the Demonstration Encounter Data submission requirements; and,
  - 2.7.8.8.13. Marketing practice guidelines and the responsibility of the Provider when representing the CICO.
- 2.7.8.9. The CICO must train its medical, behavioral, and LTSS Providers on disability literacy, including, but not limited to, the following information:
- 2.7.8.9.1. Various types of chronic conditions prevalent within the target population;
  - 2.7.8.9.2. Awareness of personal prejudices;
  - 2.7.8.9.3. Legal obligations to comply with the ADA and Patient Self-Determination Act requirements;

- 2.7.8.9.4. Definitions and concepts, such as communication access, medical equipment access, physical access, and access to programs;
  - 2.7.8.9.5. Types of barriers encountered by the target population;
  - 2.7.8.9.6. Training on person-centered planning and self-determination, the social model of disability, the Independent Living Philosophy, and the recovery model;
  - 2.7.8.9.7. Use of evidence-based practices and specific levels of quality outcomes; and
  - 2.7.8.9.8. Working with Enrollees with mental health diagnoses, including crisis prevention and treatment.
- 2.7.8.10. Provider Manual: The Provider Manual shall be a comprehensive online reference tool for the Provider and staff regarding, but not limited to, administrative, prior authorization, and referral processes, claims and Encounter Data submission processes, and plan benefits. The Provider Manual shall also address topics such as clinical practice guidelines, availability and access standards, Care Management programs and Enrollee rights, including Enrollees rights not to be balanced billed. The CICO must include in the Provider Manual a provision explaining that the CICO may not limit a Provider's communication with Enrollees as provided in Section 2.7.7.3.
- 2.7.8.11. Provider and Pharmacy Directory. The CICO shall make its Provider and Pharmacy Directory available to Providers via the CICO's web-portal.
- 2.7.8.12. The CICO shall educate Providers through a variety of means including, but not limited to, Provider alerts or similar written issuances, about their legal obligations under state and federal law to communicate with Enrollees and Eligible Beneficiaries with limited English proficiency, including the provision of interpreter services, and the resources available to help Providers comply with those obligations. All such written communications shall be subject to review at SCDHHS's and CMS' discretion.
- 2.7.9. Subcontracting Requirements
- 2.7.9.1. The CICO remains fully responsible for meeting all of the terms and requirements of the Contract regardless of whether the CICO subcontracts for performance of any Contract responsibility. The CICO shall require each First Tier, Downstream or Related Entity to

meet all terms and requirements of the Contract that are applicable to such First Tier, Downstream or Related Entity. No subcontract will operate to relieve the CICO of its legal responsibilities under the Contract.

- 2.7.9.2. The CICO is responsible for the satisfactory performance and adequate oversight of its First Tier, Downstream and Related Entities. First Tier, Downstream and Related Entities are required to meet the same federal and state financial and program reporting requirements as the CICO. The CICO is required to evaluate any potential CICO prior to delegation, pursuant to 42 C.F.R. § 438.20. Additional information about subcontracting requirements is contained in Appendix E.
- 2.7.9.3. The CICO must establish contracts and other written agreements between the CICO and First Tier, Downstream and Related Entities for Covered Services not delivered directly by the CICO or its employees.

## 2.8. Enrollee Access to Services

### 2.8.1. General

- 2.8.1.1. The CICO must authorize, arrange, coordinate and ensure the provision of all Medically Necessary Covered Services for Enrollees, as specified in Section 2.4 and Appendix A, in accordance with the requirements of the Contract. Services shall be available twenty-four (24) hours a day, seven (7) days a week when Medically Necessary. Both SCDHHS and CMS will monitor access to items and services through survey, utilization, ICP, and complaints data to assess the need for CICO Provider Network corrective actions
- 2.8.1.2. The CICO is directly responsible for the provision of all other Medically Necessary Covered Services (regardless of whether access is through a subcontracted behavioral health organization that is accountable to the CICO and for which the CICO is accountable to SCDHHS, or directly through the CICO's Provider Network).
- 2.8.1.3. The CICO must offer adequate choice and availability of primary, specialty, acute care, behavioral health and LTSS support Providers that meet CMS and SCDHHS standards as provided for in Section 2.6.9.7;
- 2.8.1.4. The CICO must at all times cover the appropriate level of service for all Emergency Services and non-Emergency Services in an appropriate setting;
- 2.8.1.5. Network Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Enrollees.

- 2.8.1.6. The CICO must reasonably accommodate Enrollees and shall ensure that the programs and services are as accessible (including physical and geographic access) to an Enrollee with disabilities as they are to an Enrollee without disabilities. The CICO and its Network Providers must comply with the ADA (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. The CICO shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit Enrollees with disabilities from obtaining all Covered Services from the CICO by:
- 2.8.1.6.1. Providing flexibility in scheduling to accommodate the needs of the Enrollees;
  - 2.8.1.6.2. Providing interpreters or translators for Enrollees who are deaf and hard of hearing and those who do not speak English;
  - 2.8.1.6.3. Ensuring that Enrollees with disabilities are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services. Reasonable accommodations will depend on the particular needs of the Enrollee and include but are not limited to:
    - 2.8.1.6.3.1. Providing large print (at least 16-point font) versions of all written materials to Enrollee with visual impairments;
    - 2.8.1.6.3.2. Ensuring that all written materials are available in formats compatible with optical recognition software;
    - 2.8.1.6.3.3. Reading notices and other written materials to Enrollee upon request;
    - 2.8.1.6.3.4. Assisting Enrollee in filling out forms over the telephone;
    - 2.8.1.6.3.5. Ensuring effective communication to and from Enrollee with disabilities through email, telephone, and other electronic means;

- 2.8.1.6.3.6. Providing TTY, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters for the deaf; and
  - 2.8.1.6.3.7. Providing individualized forms of assistance.
  - 2.8.1.6.3.8. Ensuring safe and appropriate physical access to buildings, services and equipment;
  - 2.8.1.6.3.9. Demonstrating compliance with the ADA by conducting an independent survey or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance and monitoring correction of deficiencies;
- 2.8.1.7. When the Food and Drug Administration (FDA) determines a drug to be unsafe, the CICO shall remove it from the formulary immediately. The CICO must make a good faith effort to give written notification of removal of this drug from the formulary and the reason for its removal, within five (5) days after the removal, to each Enrollee with a current or previous prescription for the drug. The CICO must also make a good faith effort to call, within three (3) calendar days, each Enrollee on an active course of therapy with the drug; a good faith effort must involve no fewer than three (3) phone call attempts at different times of day.
- 2.8.1.8. The CICO is required to coordinate Enrollee transportation/escort, including for non-emergent and non-medical needs.
- 2.8.2. Services Not Subject to Prior Approval
- 2.8.2.1. The CICO will assure coverage of Emergency Medical Conditions and Urgent Care services. The CICO must not require prior approval for the following services:
- 2.8.2.1.1. Any services for Emergency Medical Conditions as defined in 42 C.F.R §§ 422.113(b)(1) and 438.114(a) (which includes emergency behavioral health care);
  - 2.8.2.1.2. Urgent Care sought outside of the Service Area;



- 2.8.2.1.3. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical Provider is unavailable or inaccessible;
  - 2.8.2.1.4. Family planning services; and
  - 2.8.2.1.5. Out-of-area renal dialysis services; and
  - 2.8.2.1.6. Prescription drugs as required in Appendix F.
- 2.8.3. Authorization of Services
- 2.8.3.1. CICO shall authorize services as in accordance with 42 C.F.R. § 438.210.
  - 2.8.3.2. For the processing of requests for initial and continuing authorizations of Covered Services, the CICO and any First Tier, Downstream, or Related Entities shall:
    - 2.8.3.2.1. Have in place and follow written policies and procedures;
    - 2.8.3.2.2. Have in place procedures to allow Enrollees to initiate requests for provision of services;
    - 2.8.3.2.3. Have mechanisms in effect to ensure the consistent application of review criteria for authorization decisions; and
    - 2.8.3.2.4. Consult with the requesting Provider when appropriate.
  - 2.8.3.3. The CICO shall ensure that a physician and a behavioral health Provider are available twenty-four (24) hours a day for timely authorization of Medically Necessary services, including, if necessary, the transfer of the Enrollee who presented to an emergency department with an Emergency Medical Condition that has been Stabilized. The CICO's Medical Necessity guidelines must, at a minimum, be no more restrictive than Medicare standards for acute services and prescription drugs and Medicaid standards for LTSS and community mental health and substance abuse services.
  - 2.8.3.4. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment. Behavioral

health services denials must be rendered by board-certified or board-eligible psychiatrists or by a clinician licensed with the same or similar specialty as the behavioral health services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.

2.8.3.5. The CICO shall assure that all behavioral health authorization and UM activities are in compliance with 42 U.S.C. § 1396u-2(b)(8). CICO must comply with the requirements for demonstrating parity for both cost sharing (co-payments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits.

2.8.3.6. The CICO must notify the requesting Provider, either orally or in writing, and give the Enrollee written notice of any decision by the CICO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice must meet the requirements of 42 C.F.R. § 438.404 and Section 2.11, and must:

2.8.3.6.1. Be produced in a manner, format, and language that can be easily understood;

2.8.3.6.2. Be made available in Prevalent Languages, upon request; and

2.8.3.6.3. Include information, in the most commonly used languages about how to request translation services and Alternative Formats.

2.8.3.7. The CICO must make authorization decisions in the following timeframes provide notice that meet the timing requirements set forth in 42 C.F.R. § 438.404:

2.8.3.7.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.8.3.7.1.1. The Enrollee or the Provider requests an extension, or

2.8.3.7.1.2. The CICO can justify (to the satisfaction of SCDHHS and/or CMS upon request) that:

- 2.8.3.7.1.2.1. The extension is in the Enrollee's interest; and
  - 2.8.3.7.1.2.2. There is a need for additional information where:
  - 2.8.3.7.1.2.3. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
  - 2.8.3.7.1.2.4. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.
- 2.8.3.7.2. For expedited service authorization decisions, where the Provider indicates or the CICO determines that following the standard timeframe in Section 2.8.3.7 could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the CICO must make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:
- 2.8.3.7.2.1. The Enrollee or the Provider requests an extension; or
  - 2.8.3.7.2.2. The CICO can justify (to SCDHHS and/or CMS upon request) that:
  - 2.8.3.7.2.3. The extension is in the Enrollee's interest; and
  - 2.8.3.7.2.4. There is a need for additional information where:
    - 2.8.3.7.2.4.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
    - 2.8.3.7.2.4.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.8.3.7.3. In accordance with 42 C.F.R. §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct UM activities for the CICO must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollee.

2.8.4. Utilization Management/Authorization Program Description

2.8.4.1. The CICO's UM programs shall comply with CMS requirements and timeframes for historically Medicare primary paid services in addition to the requirements for historically Medicaid primary paid services.

2.8.4.2. The CICO must have a written UM program description which includes procedures to evaluate Medical Necessity, criteria used, information source, and the process used to review and approve or deny the provision of medical and long term care services. The CICO's UM program must ensure consistent application of review criteria for authorization decisions; and must consult with the requesting Provider when appropriate. The program shall demonstrate that Enrollees have equitable access to care across the network and that UM decisions are made in a fair, impartial, and consistent manner that serves the best interests of the Enrollees. The program shall reflect the standards for UM from the most current NCQA Standards when applicable. The program must have mechanisms to detect under-utilization and/or over-utilization of care including, but not limited to, Provider profiles.

2.8.4.3. In accordance with 42 C.F.R. § 438.210, any decision to deny a authorization request or to authorize a service in an amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's condition or disease. Additionally the CICO and its First Tier, Downstream, and Related Entities are prohibited from providing compensation to UM staff in a manner so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Enrollee. The CICO shall notify the requesting Provider, and give the Enrollee 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.

2.8.4.4. The following timeframe for decision requirements apply to service authorization requests, per 42 C.F.R. § 438.210:

2.8.4.4.1. Standard Authorization Decisions

2.8.4.4.1.1. For standard authorization decisions, the CICO shall provide the decision notice as expeditiously as the Enrollee's health condition requires, 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:

2.8.4.4.1.1.1. The Enrollee or the Provider requests extension; or

2.8.4.4.1.1.2. The CICO justifies to SCDHHS and CMS upon request that the need for additional information per 42 C.F.R. § 438.210. (d)(1)(ii) is in the Enrollee's interest.

#### 2.8.4.4.2. Expedited Authorization Decisions

2.8.4.4.2.1. For cases in which a Provider indicates, or the CICO determines, that following the standard timeframe could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the CICO must make an expedited authorization decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than three (3) calendar days after receipt of the request for service.

2.8.4.4.2.2. The CICO may extend the three (3) calendar days turnaround timeframe by up to fourteen (14) calendar days if the Enrollee requests an extension or the CICO justifies to SCDHHS and CMS a need for additional information and how the extension is in the Enrollee's interest.

2.8.4.4.2.3. If the CICO delegates responsibilities for UM to a First Tier, Downstream or Related Entity, the contract must have a mechanism in place to ensure that these standards are met by the First Tier, Downstream or Related Entity. The UM plan shall be submitted annually to SCDHHS and upon revision.

2.8.4.4.2.4. The CICO shall assume responsibility for all Covered Services authorized by SCDHHS, CMS or a previous CICO, which are rendered after the Enrollment effective date unless the completed ICP dictates otherwise.

2.8.4.4.3. Behavioral Health and Substance Abuse Treatment Service Authorization Policies and Procedures. The CICO shall:

2.8.4.4.3.1. Review and update annually, at a minimum, all of the behavioral health and substance abuse treatment clinical criteria and other clinical protocols that the CICO may develop and utilize in its clinical case reviews and Care Management activities. Submit any modifications to SCDHHS annually for review and approval. In its review and update process, the CICO shall consult with clinical experts either within its own clinical and medical staff or medical consultants outside of the CICO's organization, who are familiar with standards and practices of mental health and substance use treatment in South Carolina. CICO shall ensure that clinical criteria are based on current research, relevant quality standards and evidence-based models of care.

2.8.4.4.3.2. Review and update annually and submit for SCDHHS approval, at a minimum, all of its behavioral health and substance abuse treatment services authorization policies and procedures, including both in-patient and out-patient services.

2.8.4.4.3.3. Develop and maintain Behavioral Health Inpatient Services authorization policies and procedures, which shall, at a minimum, contain the following requirements:

- 2.8.4.4.3.3.1. If prior authorization is required for any Behavioral Health Inpatient Services admission for acute care, assure the availability of such prior authorization twenty-four (24) hours a day, seven (7) days a week; access to a reviewer and response to a request for authorization is within established timeliness standards aligned with the level of urgency of the request, ensuring the safety of an Enrollee at all times;
- 2.8.4.4.3.3.2. A plan and a system in place to direct Enrollees to the least restrictive environment and the least intensive yet the most clinically appropriate service to safely and adequately treat the Enrollee;
- 2.8.4.4.3.3.3. A process to render an authorization and communicate the authorized length of stay to the Enrollee, facility, and attending physician for all behavioral health emergency inpatient admissions verbally within thirty (30) minutes after admission, and within two hours after admission for non-emergency inpatient authorization and in writing within twenty-four (24) hours after admission;
- 2.8.4.4.3.3.4. Processes to ensure safe placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed and to avoid delay of onset of treatment to minimize risk to Enrollee;
- 2.8.4.4.3.3.5. A system to provide concurrent clinical reviews for continued stay in Behavioral Health Inpatient Services. CICO to monitor Medical Necessity for the clinical need for continued stay, and progress toward and achievement of Behavioral Health Inpatient Services treatment goals and objectives;

- 2.8.4.4.3.3.6. Verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans based on updated clinical reports of Enrollee's status and response to existing treatment plan; and
- 2.8.4.4.3.3.7. Processes to ensure that treatment and discharge needs are addressed at the time of initial authorization and concurrent review, and that treatment planning includes coordination with the PCP and other service providers, such as community-based mental health services Providers, as appropriate;
- 2.8.4.4.3.4. Develop and maintain Behavioral Health and substance abuse treatment Outpatient Services policies and procedures which shall include, but are not limited to, the following:
  - 2.8.4.4.3.4.1. Policies and procedures to authorize Behavioral Health and substance abuse treatment Outpatient Services for initial and ongoing requests for outpatient care;
  - 2.8.4.4.3.4.2. Policies and procedures to authorize Behavioral Health and substance abuse treatment Outpatient Services based upon behavioral health clinical criteria, based on current research, relevant quality standards and evidence-based models of care; and,
  - 2.8.4.4.3.4.3. Review and update annually, at a minimum, and submit for SCDHHS approval its Behavioral Health and substance abuse treatment Outpatient Services policies and procedures.
- 2.8.5. Authorization of LTSS
  - 2.8.5.1. The CICO must develop an authorization process for the LTSS listed in Covered Services Definitions.
  - 2.8.5.2. At a minimum, the CICO's authorization of LTSS must comply with SCDHHS' fee-for-service authorization criteria for those Covered Services. However, the CICO has the discretion to authorize services similar to HCBS more broadly in terms of criteria, amount, duration



and scope, if the ICP determines that such authorization would provide sufficient value to the Enrollee's care. Value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the Enrollee in the least restrictive setting with reduced reliance on emergency department use, acute inpatient care and institutional LTSS.

#### 2.8.6. Services for Specific Populations

- 2.8.6.1. As appropriate, the CICO shall coordinate with additional state agencies, to include, but not be limited to: The South Carolina Department of Social Services; Lt. Governor's Office on Aging; South Carolina Department of Mental Health; South Carolina Department of Alcohol and Other Drug Abuse Services; South Carolina Department of Disabilities and Special Needs and the South Carolina Commission for the Blind.
- 2.8.6.2. The CICO shall deliver preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, other screenings or services as specified in guidelines set by SCDHHS or, where there are no SCDHHS guidelines, in accordance with nationally accepted standards of practice.
- 2.8.6.3. The CICO shall provide family planning services in accordance with covered services outlined in Section 2.4.
- 2.8.6.4. The CICO shall provide systems and mechanisms designed to make Enrollees' medical history and treatment information available, within applicable legal limitations, at the various sites where the same Enrollee may be seen for care, especially for Enrollees identified as homeless. While establishing fully integrated delivery system, the CICO shall respect the privacy of Enrollees. The CICO shall comply with Section 5.2 regarding compliance with laws and regulations relating to confidentiality and privacy.

#### 2.8.7. Emergency and Post-stabilization Care Coverage

- 2.8.7.1. The CICO's Provider Network must ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community. The CICO must cover and pay for any services obtained for Emergency Medical Conditions in accordance with 42 C.F.R. § 438.114(b), (c), and (d).
- 2.8.7.2. The CICO shall require Providers to notify the Enrollee's PCP of an Enrollee's screening and treatment, but may not refuse to cover Emergency Services based on their failure to do so.

- 2.8.7.3. An Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- 2.8.7.4. The attending emergency physician, or the Provider actually treating the Enrollee, is responsible for determining when the Enrollee is sufficiently Stabilized for transfer or discharge. That determination is binding on the CICO if:
  - 2.8.7.4.1. Such transfer or discharge order is consistent with generally accepted principles of professional medical practice; and
- 2.8.7.5. The CICO shall cover and pay for Post-stabilization Care Services in accordance with 42 C.F.R. §§ 438.114(e) and 422.113(c).
- 2.8.7.6. CICO shall cover Post-Stabilization Care Services provided by a Network or non-Network Provider in any of the following situations:
  - 2.8.7.6.1. The CICO authorized such services;
  - 2.8.7.6.2. Such services were administered to maintain the Enrollee's Stabilized condition within one (1) hour after a request to the CICO for authorization of further Post-Stabilization Care Services; or
  - 2.8.7.6.3. The CICO does not respond to a request to authorize further Post-Stabilization Care Services within one (1) hour, the CICO could not be contacted, or the CICO and the treating Provider cannot reach an agreement concerning the Enrollee's care and an Network Provider is unavailable for a consultation, in which case the treating Provider must be permitted to continue the care of the Enrollee until an Network Provider is reached and either concurs with the treating Provider's plan of care or assumes responsibility for the Enrollee's care.
- 2.8.8. Emergency Medical Treatment and Labor Act (EMTALA)
  - 2.8.8.1. The CICO and Providers shall comply with EMTALA, which, in part, requires:
    - 2.8.8.1.1. Qualified hospital medical personnel to provide appropriate medical screening examinations to any Enrollee who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b);

- 2.8.8.1.2. As applicable, to provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, appropriate transfers; and
- 2.8.8.1.3. The CICO's contracts with its Providers must clearly state the Provider's EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.

## 2.8.9. Availability of Services

- 2.8.9.1. Access to Services for Emergency Conditions and Urgent Care. The CICO shall:
  - 2.8.9.1.1. Have a process established to notify the PCP or MT (or the designated covering physician) of an Emergency Condition within one business day after the CICO is notified by the Provider. If the CICO is not notified by the Provider within ten (10) calendar days of the Enrollee's presentation for Emergency Services, the CICO may not refuse to cover Emergency Services.
  - 2.8.9.1.2. Have a process to notify the PCP or MT of required Urgent Care within twenty-four (24) hours of the CICO being notified.
  - 2.8.9.1.3. Record summary information about Emergency Medical Conditions and Urgent Care services in the Enrollee Medical Record no more than eighteen (18) hours after the PCP or MT is notified, and a full report of the services provided within two (2) business days.
  - 2.8.9.1.4. Pay the Provider or reimburse the Enrollee, in the fee-for-service amount that would have been paid by Medicare and/or SCDHHS, if services are obtained out of network for emergency conditions. This must be done within sixty (60) calendar days after the claim has been submitted. The CICO must ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network.

- 2.8.9.1.5. Cover and pay for any services obtained for Emergency Medical Conditions in accordance with 42 C.F.R. § 438.114(c). The CICO may not deny payment for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R. § 438.114(a) of the definition of Emergency Medical Condition.
- 2.8.9.1.6. Ensure that an Enrollee who has an Emergency Medical Condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
- 2.8.9.2. All urgent and symptomatic office visits must be available to Enrollees within twenty-four (24) hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention;
- 2.8.9.3. All non-symptomatic office visits must be available to Enrollees within thirty (30) calendar days;
- 2.8.9.4. The following minimum appointment availability standards apply to physical health and behavioral health services:
  - 2.8.9.4.1. For Emergency Services: immediately upon presentation at a service delivery site.
  - 2.8.9.4.2. For urgent care: within twenty-four (24) hours of request.
  - 2.8.9.4.3. Non-urgent “sick” visit: within forty-eight (48) to seventy-two (72) hours of request, as clinically indicated.
  - 2.8.9.4.4. Routine non-urgent, preventive appointments: within four (4) weeks of request.
  - 2.8.9.4.5. Specialist referrals (not urgent): within two (2) to four (4) weeks of request.
  - 2.8.9.4.6. Pursuant to an emergency or hospital discharge, mental health or substance abuse follow-up visits with a Provider (as included in the Covered Services): within five (5) days of request, or as clinically indicated.

2.8.9.4.7. Non-urgent mental health or substance abuse visits with a provider (as included in the Covered Services): within two (2) weeks of request.

2.8.9.4.8. Provider visits to make health, mental health, and substance abuse assessments for the purpose of making recommendations regarding a recipient's ability to perform work within ten (10) days of request.

## 2.8.10. Linguistic Competency

2.8.10.1. The CICO must demonstrate linguistic competency in its dealing, both written and verbal, with Enrollees and must understand that linguistic differences between the Provider and the Enrollee cannot be permitted to present barriers to access and quality health care and demonstrate the ability to provide quality health care across a variety of cultures.

## 2.8.11. Access for Enrollees with Disabilities

2.8.11.1. The CICO and its Providers must comply with the ADA (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees.

2.8.11.2. The CICO and its Providers can demonstrate compliance with the ADA by conducting an independent survey/site review of facilities for both physical and programmatic accessibility.

2.8.11.3. Physical and telephonic access to services must be made available for individuals with disabilities and fully comply with the ADA.

2.8.11.4. The CICO must reasonably accommodate persons with disabilities and ensure that physical and communication barriers do not inhibit individuals with disabilities from obtaining services from the CICO.

2.8.11.5. The CICO must have policies and procedures in place demonstrating a commitment to accommodating the physical access and flexible scheduling needs of Enrollees, in compliance with the ADA. This includes the use of TTY/TDD devices for the Deaf and hard of hearing, qualified American Sign Language (ASL) interpreters and alternative cognitively accessible communication for persons with cognitive limitations.

## 2.9. Required Call Centers

### 2.9.1. Enrollee Services Call Center

- 2.9.1.1. The CICO must operate a customer service call center during normal business hours, and never less than from 8:00 a.m. to 8:00 p.m. (EST), seven (7) days a week, consistent with the required Marketing Guidelines.
- 2.9.1.2. Enrollee service representatives (ESRs) must be available Monday through Friday, at least from 8:00 a.m. to 8:00 p.m. (EST). The CICO may use alternative call center technologies on Saturdays, Sundays, and federal holidays.
- 2.9.1.3. A toll-free TTY number or state relay service must be provided.
- 2.9.1.4. Call Center Performance
  - 2.9.1.4.1. The CICO's ESR's must answer eighty percent (80%) of all Enrollee telephone calls within thirty (30) seconds or less.
  - 2.9.1.4.2. The CICO must limit the average hold time to two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting, and before reaching a live person.
  - 2.9.1.4.3. The CICO must limit the disconnect rate of all incoming calls to five percent (5%).
  - 2.9.1.4.4. The CICO must have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question in the Enrollee's language or mode of communication and in a manner that is sensitive to the Enrollee's cultural needs.
  - 2.9.1.4.5. Customer service call centers must meet all applicable standards for SCDHHS contracted call centers including:
    - 2.9.1.4.5.1. Capability to record calls and retrieve calls within one (1) business day following a request by SCDHHS. Maintain the ability to retain calls for up to ten (10) years;

- 2.9.1.4.5.2. Capability to have callers remain in queue via a call-back function, whereby a caller is able to hang up and receive an automated call-back at their point in the queue;
- 2.9.1.4.5.3. Capability to transfer calls to third parties as directed by SCDHHS for additional service(s) and/or for customer service and other surveys by a third party;
- 2.9.1.4.5.4. Screen, train, monitor, and supervise adequate staff to receive calls, providing training and quality assurance tools that will be used to ensure consistency of service;
- 2.9.1.4.5.5. Provide appropriate training to all staff that have or may have access to the infrastructure used to provide the ESR services in a manner that meets or exceeds the requirements of HIPAA and any other applicable SCDHHS policy, state or federal laws;
- 2.9.1.4.5.6. Maintain data on each contact that includes purpose of the service request, the type of service(s) provided including any referral information, and the outcomes of the contact;
- 2.9.1.4.5.7. Provide standard monthly statistical reports to SCDHHS on inbound phone calls including the following data elements:
  - 2.9.1.4.5.7.1. Calls offered;
  - 2.9.1.4.5.7.2. Calls answered;
  - 2.9.1.4.5.7.3. Time of day call volumes (charts/graph by fifteen (15) minute increments);
  - 2.9.1.4.5.7.4. Calls routed out of call center by customer selections (counts);
  - 2.9.1.4.5.7.5. Minimum, maximum, average, standard deviations for wait times (before answer and before abandon);
  - 2.9.1.4.5.7.6. Minimum, maximum, average, standard deviations for length of call;

- 2.9.1.4.5.7.7. Call purpose and action taken (from pre-determined lists);
  - 2.9.1.4.5.7.8. Monthly monitoring activity and quality report;
  - 2.9.1.4.5.7.9. Message call-back/response time report;
  - 2.9.1.4.5.7.10. Interruptions of service; and
  - 2.9.1.4.5.7.11. Recommendations to SCDHHS to improve service delivery under this Demonstration as part of regular monthly reporting.
- 2.9.1.4.5.8. Review and/or address any issues that may arise during monthly meeting with SCDHHS;
  - 2.9.1.4.5.9. Notify SCDHHS of any disruption or irregularity in service within thirty (30) minutes of recognition or knowledge of the problem.
- 2.9.1.4.6. Performance Standards and Penalties
- 2.9.1.4.6.1. The CICO shall maintain the following performance standards relative to the delivery of the services:
    - 2.9.1.4.6.1.1. Inbound callers must have access to the automated call distribution system one hundred percent (100%) of the time, callers may not receive a busy signal. SCDHHS may penalize the CICO up to five hundred dollars (\$500) per day for each day that the total capacity of the telephony infrastructure is exceeded and reasonable evidence that callers received a busy signal exists.
    - 2.9.1.4.6.1.2. SCDHHS may penalize the CICO up to five hundred dollars (\$500) per day for each day that the inbound call service level was not met.



- 2.9.1.4.6.1.3. Hours of operation must be met as set forth in this Contract. SCDHHS may penalize the CICO up to five hundred dollars (\$500) per day for each day that the call center does not answer calls during the expected hours of operation.
  - 2.9.1.4.6.1.4. Messages left during call center operating hours must be returned within the same business day and after-hours message must be responded to during the next business day. SCDHHS may penalize the CICO up to five hundred dollars (\$500) per day for each day that messages are not returned in a timely manner as defined herein.
  - 2.9.1.4.6.1.5. The CICO shall monitor at least one percent (1%) of calls each month and assess the quality of the response provided to the caller for customer service and accuracy evaluation criteria. SCDHHS shall be able to review all calls monitored and make an independent assessment. These quality surveys performed by SCDHHS shall be graded and the total quality scores of these surveys shall exceed eighty percent (80%) for a given month. SCDHHS may penalize the CICO up to five thousand dollars (\$5,000) per month for each month that the call center did not meet the quality performance measure.
- 2.9.1.5. Informational calls to the CICO's call centers that become sales/Enrollment calls at the proactive request of the Eligible Beneficiary must be transferred to SCDHHS's authorized agent.
- 2.9.1.6. Enrollee Service Representatives (ESRs)
- 2.9.1.6.1. The CICO must employ ESRs trained to answer Enrollee inquiries and concerns from Enrollees and Eligible Beneficiaries, consistent with the requirements of 42 CFR §§ 422.111(h) and 423.128(d).
  - 2.9.1.6.2. ESRs must be trained to answer Enrollee inquiries and concerns from Enrollees and prospective Enrollees;

- 2.9.1.6.3. ESRs must be trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternative Formats;
- 2.9.1.6.4. ESRs must be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including ASL, or through an alternative language device or telephone translation service;
- 2.9.1.6.5. ESRs must inform callers that interpreter services are free.
- 2.9.1.6.6. ESRs must be knowledgeable about South Carolina Medicaid, Medicare, and the terms of the Contract, including the Covered Services listed in Appendix A;
- 2.9.1.6.7. ESRs must be available for Enrollees to discuss and provide assistance with resolving Enrollee Complaints;
- 2.9.1.6.8. ESRs must have access to the CICO's Enrollee database and an electronic Provider and Pharmacy Directory;
- 2.9.1.6.9. ESRs must make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees, including ASL;
- 2.9.1.6.10. ESRs must maintain the availability of services, such as TTY services, computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for deaf and hard of hearing Enrollees;
- 2.9.1.6.11. ESRs must demonstrate sensitivity to culture, including disability culture and the Independent Living Philosophy;
- 2.9.1.6.12. ESRs must provide assistance to Enrollees with cognitive impairments; for example, provide written materials in simple, clear language at or below sixth (6<sup>th</sup>) grade reading level, and individualized guidance from ESRs to ensure materials are understood;

- 2.9.1.6.13. ESRs must provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the CICO;
- 2.9.1.6.14. ESRs must maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives; and
- 2.9.1.6.15. ESRs must ensure that ESRs make available to Enrollees and Eligible Beneficiaries, upon request, information concerning the following:
  - 2.9.1.6.15.1. The identity, locations, qualifications, and availability of Providers;
  - 2.9.1.6.15.2. Enrollees' rights and responsibilities;
  - 2.9.1.6.15.3. The procedures available to an Enrollee and Provider(s) to challenge or appeal the failure of the CICO to provide a Covered Service and to Appeal any Adverse Actions (denials);
  - 2.9.1.6.15.4. How to access oral interpretation services and written materials in Prevalent Languages and Alternative Formats;
  - 2.9.1.6.15.5. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;
  - 2.9.1.6.15.6. The procedures for an Enrollee to change plans or to opt out of the Demonstration; and,
  - 2.9.1.6.15.7. Additional information that may be required by Enrollees and Eligible Beneficiaries to understand the requirements and benefits of the CICO's plan.

## 2.9.2. CICO-Operated Nurse Support Line

- 2.9.2.1. The CICO must provide a twenty-four (24) hour-per-day, seven (7) days-per-week, toll-free system with access to a registered nurse who:
  - 2.9.2.1.1. Has immediate access to the Enrollee medical record;

- 2.9.2.1.2. Is able to respond to Enrollee questions about health or medical concerns;
  - 2.9.2.1.3. Has the experience and knowledge to provide clinical triage;
  - 2.9.2.1.4. Is able to provide options other than waiting until business hours or going to the emergency room; and,
  - 2.9.2.1.5. Is able to provide access to oral interpretation services available as needed, free-of-charge.
- 2.9.2.2. The CICO shall ensure that the nurses staffing the nurse advice line will be able to obtain Physician support and advice by contacting the CICO's Medical Director if needed.
- 2.9.3. Provider Practice After Hours Support Line
- 2.9.3.1. The CICO shall require PCPs and specialty Provider contracts to provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voicemail alone after hours is not acceptable.
- 2.9.4. Pharmacy Technical Help Call Center
- 2.9.4.1. The CICO shall operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers regarding the Enrollee's prescription drug benefit; inquiries may pertain to operational areas such as claims processing, benefit coverage, claims submission, and claims payment. This requirement can be accommodated through the use of on-call staff pharmacists or by contracting with the CICO's pharmacy benefit manager during non-business hours as long as the individual answering the call is able to address the call at that time. The call center must operate or be available during the entire period in which the CICO's network pharmacies in its plans' Service Areas are open, (e.g., CICOs whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call centers twenty-four (24) hours a day as well). The pharmacy technical help call center must meet the following operating standards:
    - 2.9.4.1.1. Average hold time must not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response (IVR) system, touch tone response system, or recorded greeting and before reaching a live person.

2.9.4.1.2. Eighty percent (80%) of incoming calls answered within thirty (30) seconds.

2.9.4.1.3. Disconnect rate of all incoming calls not to exceed five percent (5%).

## 2.9.5. Coverage Determinations and Appeals Call Center

2.9.5.1. The CICO must operate a toll-free call center with live customer service representatives available to respond to Providers and Enrollees for information related to requests for coverage under Medicare and Medicaid, and Medicare and Medicaid appeals (including requests for Medicare and Medicaid exceptions and prior authorizations).

2.9.5.2. The CICO is required to provide immediate access to requests for Medicare and Medicaid covered benefits and services, including Medicare and Medicaid coverage determinations and redeterminations, via its toll-free call centers.

2.9.5.3. The coverage determination and appeals call centers must operate during normal business hours and never less than from 8:00 a.m. to 8:00 p.m. EST, Monday through Friday.

2.9.5.4. The CICO must accept requests for Medicare and Medicaid coverage, including Medicare and Medicaid coverage determinations / redeterminations, outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours.

2.9.5.5. Voicemail may be used outside of normal business hours provided that the message:

2.9.5.5.1. Indicates that the mailbox is secure;

2.9.5.5.2. Lists the information that must be provided so the case can be worked (e.g., Provider identification, Enrollee identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Enrollee is making an expedited or standard request);

2.9.5.5.3. For coverage determination calls (including exceptions requests) related to Part D, articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.9.5.5.4. For Appeals calls related to Part D, information articulates the process information needed and provide for a resolution within seventy-two (72) hours for expedited Appeal requests and seven (7) calendar days for standard Appeal requests.

## 2.10. Enrollee Grievance

### 2.10.1. Grievance Filing

- 2.10.1.1. Internal Grievance Filing: An Enrollee, or an authorized representative, may file an internal Enrollee Grievance at any time with the CICO or its Providers by calling or writing to the CICO or Provider. If the internal Enrollee Grievance is filed with a Provider, the CICO must require the Provider to forward it to the CICO. If remedial action is requested regarding a Medicare issue, the Enrollee must file the Grievance with the CICO or Provider no later than sixty (60) days after the event or incident triggering the Grievance.
- 2.10.1.2. External Grievance Filing: The CICO shall inform Enrollees that they may file an external Grievance through 1-800 Medicare. The CICO must display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the CICO's main Web page per 42 C.F.R. § 422.504(b)(15)(ii). The CICO must inform Enrollees of the email address, postal address or toll-free telephone number where an Enrollee Grievance may be filed.
- 2.10.1.3. External Grievances filed with SCDHHS or the Demonstration Ombudsman shall be entered into the CMS Complaints tracking module, which will be accessible to the CICO.
- 2.10.1.4. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

### 2.10.2. Grievance Administration

- 2.10.2.1. The CICO must have a formally structured Grievance system, consistent with 42 C.F.R. § 438 Subpart F, and the [SCDHHS Managed Care Policies and Procedures Guide](https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp) (<https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp>), in place for addressing Enrollee Grievances, including Grievances regarding reasonable accommodations and access to services under the ADA.
- 2.10.2.2. The CICO Grievance procedures must meet the following standards:

- 2.10.2.2.1. Timely acknowledgement of receipt of each Enrollee Grievance;
  - 2.10.2.2.2. Timely review of each Enrollee Grievance;
  - 2.10.2.2.3. Response and disposition, electronically, orally or in writing, to each internal (plan-level) Enrollee Grievance within a reasonable time, but no later than five (5) business days after the CICO receives the Grievance;
  - 2.10.2.2.4. Response and disposition, electronically, orally or in writing, to each formal (external) Enrollee Grievance within a reasonable time, but no later than 30 days after the CICO receives the Grievance;
  - 2.10.2.2.5. Expedited response and disposition, orally or in writing, within twenty-four (24) hours after the CICO receives the Grievance, to each Enrollee Grievance whenever CICO extends the Appeal timeframe beyond thirty (30) calendar days or CICO refuses to grant a request for an expedited Appeal; and
  - 2.10.2.2.6. Availability to Enrollees of information about Enrollee Grievances and Appeals, as described in Subsection 2.10.2.2.7, including reasonable assistance in completing any forms or other procedural steps, which shall include interpreter services and toll-free numbers with TTY/TDD and interpreter capability.
  - 2.10.2.2.7. Method, including content, of notice of resolution of grievances to be submitted to SCDHHS for prior approval.
- 2.10.2.3. The CICO must maintain written records of all Grievance activities, and notify CMS and SCDHHS of all internal Enrollee Grievances.
- 2.10.2.4. The CICO must ensure that the individuals who make decisions on grievances (1) were not involved in previous levels of review or decision making and, (2) if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by SCDHHS, in treating the Enrollee's clinical condition or disease:
- 2.10.2.4.1. A grievance regarding denial of expedited resolution of an appeal; or

2.10.2.4.2. A grievance that involves clinical issues.

## 2.11. Enrollee Appeals

### 2.11.1. General Requirements

2.11.1.1. All CICOs shall utilize and all Enrollees may access the existing Part D Appeals Process, as described in Appendix E. Consistent with existing rules, Part D Appeals will be automatically forwarded to the CMS Medicare Independent Review Entity (IRE) if the CICO misses the applicable adjudication timeframe. The CMS IRE is contracted by CMS. The CICO must maintain written records of all Appeal activities, and notify CMS and SCDHHS of all internal Appeals.

2.11.1.2. The CICO agrees to be fully compliant with all state and federal laws, regulations, and policies governing the State Fair Hearing process, and all statutory and regulatory timelines related thereto. This includes the requirements for both standard and expedited requests. The CICO shall be financially liable for all judgments, penalties, costs and fees related to an Appeal in which the CICO has failed to comply fully with said requirements. The CICO must maintain written records of all Appeal activities, and notify CMS and SCDHHS of all internal Appeals.

### 2.11.2. Integrated/Unified Non-Part D Appeals Process Overview

2.11.2.1. Notice of Adverse Action – In accordance with 42 C.F.R. §§ 438.404 and 422.570, the CICO must give the Enrollee written notice of any Adverse Action. Such notice shall be provided at least ten (10) calendar days in advance of the date of its action, in accordance with 42 C.F.R. § 438.404. An Enrollee or a Provider acting on behalf of an Enrollee and with the Enrollee's written consent may Appeal the CICO's decision to deny, terminate, suspend, or reduce services. In accordance with 42 C.F.R. §§ 438.402 and 422.574, an Enrollee or Provider action on behalf of an Enrollee and with the Enrollee's consent may also appeal the CICO's delay in providing or arranging for a Covered Service.

2.11.2.2. The CICO's Appeal procedures must: (i) be submitted to the CMT in writing for prior approval by CMS and SCDHHS; (ii) provide for resolution within the timeframes specified herein; and (iii) assure the participation of individuals with authority to require corrective action. Appeals procedures must be consistent with 42 CFR § 422.560 et seq. and 42 CFR § 438.400 et seq.



- 2.11.2.3. The CICO shall review its Appeal procedures at least annually for the purpose of amending such procedures when necessary.
- 2.11.2.4. The CICO shall amend its procedures only upon receiving prior approval from SCDHHS.
- 2.11.2.5. Forms that Enrollees may use to file Grievances, Appeals, concerns, or recommendations to the CICO shall be available through the CICO, and must be provided upon the Enrollees request.
- 2.11.2.6. Integrated Notice
  - 2.11.2.6.1. Enrollees will be notified of all applicable Demonstration, Medicare and Medicaid Appeal rights through a single notice. The form and content of the notice must be prior approved by CMS and SCDHHS. The CICO shall notify the Enrollee of its decision at least ten (10) days in advance of the effective date of its action. The notice must explain:
    - 2.11.2.6.1.1. The action the CICO has taken or intends to take;
    - 2.11.2.6.1.2. The reasons for the action;
    - 2.11.2.6.1.3. The citation to the regulations supporting such action;
    - 2.11.2.6.1.4. The Enrollee's or the Provider's right to file an internal Appeal with the CICO and that exhaustion of the CICO's internal Appeal processes is a prerequisite to filing an external Appeal to Medicare or to Medicaid;
    - 2.11.2.6.1.5. Procedures for exercising Enrollee's rights to Appeal;
    - 2.11.2.6.1.6. The Enrollee's right to request a State Fair Hearing in accordance with S.C. Code Ann. Regs. 126-150 through 126-158 and as described in Section 2.11.4.2;
    - 2.11.2.6.1.7. Circumstances under which expedited resolution is available and how to request it; and

- 2.11.2.6.1.8. If applicable, the Enrollee's rights to have benefits continue pending the resolution of the Appeal, and the circumstances under which the Enrollee may be required to pay the costs of these services.
- 2.11.2.6.2. Written material must use easily understood language and format, be available in Alternative Formats and in an appropriate manner that takes into consideration those with special needs. All Enrollees and Eligible Beneficiaries must be informed that information is available in Alternative Formats and how to access those formats.
- 2.11.2.6.3. Written notice must be translated for the individuals who speak Prevalent Languages.
- 2.11.2.6.4. Written notices must include language clarifying that oral interpretation is available for all languages and how to access it.
- 2.11.2.7. Appeal levels
  - 2.11.2.7.1. Initial Appeals (first level internal Appeal) will be filed with the CICO, in accordance with the timeframes and other requirements outlined in Section 2.11.3.
  - 2.11.2.7.2. Subsequent appeals for traditional Medicare A and B services that are not fully in favor of the Enrollee will be automatically forwarded to the Medicare IRE by the CICO.
  - 2.11.2.7.3. Subsequent Appeals for services covered by SCDHHS only (including, but not limited to, LTSS, South Carolina Medicaid-covered drugs excluded from Medicare Part D, and behavioral health) may be Appealed to the SCDHHS Division of Appeals and Hearings after the initial plan-level Appeal has been completed, in accordance with the timeframes and other requirements outlined in Section 2.11.4.2.

2.11.2.7.4. Appeals for services for which Medicare and Medicaid overlap (including, but not limited to, home health, durable medical equipment and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE by the CICO, and an Enrollee may also file a request for a hearing with SCDHHS Division of Appeals and Hearings. If an Appeal is filed with both the IRE and SCDHHS Division of Appeals and Hearings any determination in favor of the Enrollee will bind the CICO and will require payment by the CICO for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.

2.11.2.7.5. Prescription Drugs

2.11.2.7.5.1. Part D Appeals may not be filed with SCDHHS Division of Appeals and Hearings.

2.11.2.7.5.2. Appeals related to drugs excluded from Part D that are covered by Medicaid must be filed with SCDHHS Division of Appeals and Hearings.

2.11.2.8. Continuation of Benefits Pending an Appeal and State Fair Hearing

2.11.2.8.1. The CICO must provide continuing benefits for all prior approved non-Part D benefits that are terminated or modified pending internal CICO Appeals, per timeframes and conditions in 42 C.F.R. §438.420. This means that such benefits will continue to be provided by Providers to Enrollees and that the CICOs must continue to pay Providers for providing such services or benefits pending an internal Appeal.

2.11.2.8.2. For all Appeals filed with the SCDHHS Division of Appeals and Hearings, an Enrollee may request continuing services. SCDHHS will make a determination on continuation of services in accordance with 42 C.F.R. §438.420 and 42 CFR §431.230.

- 2.11.2.8.3. If the CICO or the state hearing officer reverses a decision to deny authorization of Covered Services, and the Enrollee did not receive the disputed services while the Appeal was pending, the CICO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires, but no later than seventy-two (72) hours from the date the CICO receives the notice reversing the decision.
- 2.11.2.8.4. If the CICO or the state hearing officer reverses a decision to deny authorization of Covered Services, and the Enrollee received the disputed services while the Appeal was pending, the CICO must pay for those services in accordance with state rules and policy.
- 2.11.2.8.5. If services were furnished while the Appeal or State Fair Hearing was pending, the CICO may recover the cost of the continuation of services furnished to the Enrollee while the Appeal was pending if the final resolution of the Appeal upholds the CICO's action.

### 2.11.3. Internal (Plan-level) Appeals

- 2.11.3.1. Initial Appeals must be filed with the CICO. The filing of an internal Appeal and exhaustion of the CICO's internal Appeal process is a prerequisite to filing an external Appeal to Medicare or Medicaid.
- 2.11.3.2. An Enrollee or his/her representative may file an oral or written Appeal with the CICO within sixty (60) calendar days following the date of the notice of Adverse Action that generates such Appeal; oral Appeals may be filed by calling the CICO at the phone number provided in the approved Member handbook.
- 2.11.3.3. Standard Appeals
  - 2.11.3.3.1. The CICO's Appeals process must include the following requirements:
    - 2.11.3.3.1.1. Acknowledge receipt of each Appeal.

- 2.11.3.3.1.2. Ensure that the individuals who make decisions on Appeals (1) were not involved in any previous level of review or decision making and (2) if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by SCDHHS, in treating the Enrollee's clinical condition or disease:
  - 2.11.3.3.1.2.1. An Appeal of a denial that is based on a lack of medical necessity; or
  - 2.11.3.3.1.2.2. An Appeal that involves clinical issues.
- 2.11.3.3.1.3. Provide that oral inquiries seeking to Appeal an action are treated as Appeals (to establish the earliest possible filing date for the Appeal) and must be confirmed in writing unless the Enrollee or the Provider appealing on the Enrollee's behalf requests expedited resolution.
- 2.11.3.3.1.4. Provide the Enrollee a reasonable opportunity to present evidence and allegations of fact or law in person as well as in writing. (The CICO must inform the Enrollee of the limited time available for this, especially in the case of expedited resolution.)
- 2.11.3.3.1.5. Provide the Enrollee and his or her representative opportunity, before and during the Appeals process, to examine the Enrollee's case file, including any medical records and any other documents and records considered during the Appeals process.
- 2.11.3.3.1.6. Consider the Enrollee, representative or estate representative of a deceased Enrollee as parties to the Appeal.
- 2.11.3.3.2. For Appeals filed with the CICO, if the Enrollee or his/her representative does not request an expedited Appeal pursuant to 42 C.F.R. § 438.410, the CICO may require the Enrollee to follow an oral Appeal with a written, signed Appeal.

2.11.3.3.3. The CICO shall issue a decision in writing to standard Appeals as expeditiously as the Enrollee's health condition requires and shall not exceed fifteen (15) calendar days from the initial date of receipt of the Appeal. The CICO may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the CICO provides evidence satisfactory to SCDHHS that there is a need for additional information and that a delay in rendering the decision is in the Enrollee's interest. For any appeals decisions not rendered within fifteen (15) calendar days where the Enrollee has not requested an extension, the CICO shall provide written notice to the Enrollee of the reason for the delay.

#### 2.11.3.4. Expedited Appeals

2.11.3.4.1. The CICO shall establish and maintain an expedited review process for Appeals where either the CICO or the Enrollee's provider determines that the time expended in a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The CICO shall ensure that punitive action is neither taken against a Provider that requests an expedited resolution nor supports the Enrollee's Appeal. In instances where the Enrollee's request for an expedited Appeal is denied, the Appeal must be transferred to the timeframe for standard resolution of Appeals and the Enrollee must be given prompt oral notice of the denial (make reasonable efforts) and a written notice within two (2) calendar days.

- 2.11.3.4.2. The CICO shall issue decisions for expedited Appeals as expeditiously as the Enrollee's health condition requires, not to exceed seventy-two (72) hours from the initial receipt of the Appeal. The CICO may extend this timeframe by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the CICO provides evidence satisfactory to SCDHHS that there is a need for additional information and that a delay in rendering the decision is in the Enrollee's interest. For any extension not requested by the Enrollee, the CICO shall provide written notice to the Enrollee of the reason for the delay. The CICO shall make reasonable efforts to provide the Enrollee with prompt verbal notice of any decisions that are not resolved wholly in favor of the Enrollee and shall follow-up within two (2) calendar days with a written notice of action.
- 2.11.3.4.3. All decisions to Appeal must be in writing and shall include, but not be limited to, the following information:
  - 2.11.3.4.3.1. The decision reached by the CICO;
  - 2.11.3.4.3.2. The rationale and regulations upon which the decision was based;
  - 2.11.3.4.3.3. The date of decision;
  - 2.11.3.4.3.4. For Appeals not resolved wholly in favor of the Enrollee;
    - 2.11.3.4.3.4.1. The right to request a State Fair Hearing and how to do so; and
    - 2.11.3.4.3.4.2. The right to request to receive benefits while the hearing is pending and how to make the request, explaining that the Enrollee may be held liable for the cost of those services if the hearing decision upholds the CICO.

#### 2.11.4. External Appeals

- 2.11.4.1. The CMS Independent Review Entity (IRE)

- 2.11.4.1.1. If, on internal Appeal, the CICO does not decide fully in the Enrollee's favor within the relevant time frame, the CICO shall automatically forward the case file regarding Medicare services to the CMS IRE for a new and impartial review. The CMS IRE is contracted by CMS.
- 2.11.4.1.2. For standard external Appeals, the CMS IRE will send the Enrollee and the CICO a letter with its decision within thirty (30) calendar days after it receives the case from the CICO, or at the end of up to a fourteen (14) calendar day extension, and a payment decision within sixty (60) calendar days.
- 2.11.4.1.3. If the CMS IRE decides in the Enrollee's favor and reverses the CICO's decision, the CICO must authorize the service under dispute as expeditiously as the Enrollee's health condition requires but no later than seventy-two (72) hours from the date the CICO receives the notice reversing the decision.
- 2.11.4.1.4. For expedited external Appeals, the CMS IRE will send the Enrollee and the CICO a letter with its decision within seventy-two (72) hours after it receives the case from the CICO (or at the end of up to a fourteen (14) calendar day extension), a pre-service decision within thirty (30) calendar days, and a payment decision within sixty (60) calendar days
- 2.11.4.1.5. If the CICO or the Enrollee disagrees with the CMS IRE's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by SCDHHS Appeals Board, and judicial review. The CICO must comply with any requests for information or participation from such further Appeal entities.

#### 2.11.4.2. The Medicaid State Fair Hearing Process



- 2.11.4.2.1. If the CICO's internal Appeal decision is not fully in the Enrollee's favor, the Enrollee may Appeal to SCDHHS Division of Appeals and Hearings for Medicaid-based adverse decisions. Appeals to the external Medicaid State Fair Hearing process will not be automatically forwarded to SCDHHS by the CICO. Such Appeals must be made in writing and may be made via US Mail, fax transmission, hand-delivery or electronic transmission. Enrollees have the option of filing an expedited Appeal by telephone.
- 2.11.4.2.2. An Appeal may be submitted orally or in writing. If the Enrollee does not request an expedited Appeal pursuant to 42 C.F.R. §438.410, the CICO may require the Enrollee to follow an oral Appeal with a written, signed Appeal. All Appeals shall be registered initially with the CICO and, if the CICO's decision is adverse to the Enrollee, the Enrollee may file an Appeal for a State Fair Hearing as provided in this Section.
- 2.11.4.2.3. An Enrollee may appoint any authorized representative, including, but not limited to, a guardian, caretaker relative, or Provider, to represent the Enrollee throughout the Appeal process. The CICO shall provide a form and instructions on how an Enrollee may appoint a representative. The CICO shall consider the Enrollee, the Enrollee's authorized representative, or the representative of the Enrollee's estate as parties to the Appeal. The CICO shall provide such parties a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The CICO shall allow such parties an opportunity, before and during the Appeal process, to examine the Enrollee's case file, including medical records and any other documents and records.
- 2.11.4.2.4. Appeals to the external Medicaid State Fair Hearing process must be filed within thirty (30) days of the date of the CICO's internal Appeal decision, unless the time period is extended by SCDHHS upon a finding of "good cause".

- 2.11.4.2.5. External Appeals to the Medicaid State Fair Hearing process that qualify as expedited Appeals shall be resolved within seventy-two (72) hours or as expeditiously as the Enrollee's condition requires. This timeframe may be extended by up to an additional fourteen (14) calendar days if the Enrollee requests the extension or if the CICO provides evidence satisfactory to SCDHHS that a delay in rendering the decision is in the Enrollee's interest. For any extension not requested by the Enrollee, the CICO shall provide written notice to the Enrollee of the reason for the delay.
- 2.11.4.2.6. External Appeals to the Medicaid State Fair Hearing process that do not qualify as expedited shall be resolved or a decision issued within ninety (90) calendar days of the date of filing the Appeal with the CICO, not including the number of days the Enrollee took to file for a State Fair Hearing.

#### 2.11.5. Hospital Discharge Appeals

- 2.11.5.1. The CICO must comply with the hospital discharge appeal requirements at 42 C.F.R. §§ 422.620-422.622
- 2.11.5.2. The Enrollee has the right to request a review by a Quality Improvement Organization (QIO) of any hospital discharge notice. The notice includes information on filing the QIO Appeal. The Enrollee must contact the QIO before he/she leaves the hospital but no later than the planned discharge date
- 2.11.5.3. If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. The CICO must ensure that the Enrollee receives the Detailed Notice of Discharge (CMS-10066). Note: An Enrollee may file an oral or written request for an expedited seventy-two (72) hour CICO Appeal if the Enrollee has missed the deadline for requesting the QIO review.
- 2.11.5.4. The QIO will make its decision within one (1) full working day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision.
- 2.11.5.5. If the QIO agrees with the CICO's decision, the CICO is not responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO notifies the Enrollee of its decision.

2.11.5.6. If the QIO overturns the CICO's decision, the CICO must pay for the remainder of the hospital stay.

#### 2.11.6. Medicare QIO Rights

2.11.6.1. The CICO must comply with the termination of services Appeal requirements for Enrollees receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facilities, or home health agency, consistent with 42 C.F.R. §§422.624 and 422.626.

#### 2.11.7. Provider Appeals

2.11.7.1. Providers should follow the CICO's Provider Appeals process as outlined in their contract and the CICO's Provider manual should they dispute the CICO policies, procedures, or any aspect of the CICOs administrative functions including payment, and/or UM/utilization review decision.

2.11.7.2. The CICO's Demonstration Provider Appeals system must align with the approved Medicaid Managed Care Provider Appeals system.

2.11.7.3. ; For Appeals related to denial of payment or reduction of payment for Medicaid services, the process must provide for the following;

2.11.7.3.1. A process to allow Providers to consolidate Appeals of multiple claims that involve the same or similar payment issues, regardless of the number of individual Enrollees or payment claims included in the bundled complaint;

2.11.7.3.2. Provide for different levels of appeals as follows:

2.11.7.3.2.1.1. The CICO must investigate and render a decision regarding level one Appeals I within thirty (30) business days of the request of the Provider Appeal.

2.11.7.3.2.1.2. To the extent the CICO upholds the decision for all or part of the amount of the dispute, the Provider may request to proceed to a level two Appeal.

2.11.7.3.2.1.2. 1. Such request must be made within thirty (30) days of the

determination regarding the level two Appeal.

- 2.11.7.3.2.1.2. 2. The level two Appeal must consist of an administrative review conducted by a supervisor and/or manager employed by the CICO with the authority to revise the initial claims determination, if needed.
- 2.11.7.3.2.1.2. 3. A decision regarding the Appeal must be provided within thirty (30) business days of the request for the Appeal.
- 2.11.7.3.2.1.2. 4. To the extent additional information is required to render a decision on the Appeal, the CICO may extend the timeframe by fifteen (15) days based on the mutual agreement of the Provider and the CICO.

## 2.12. Quality Improvement Program

### 2.12.1. The CICO shall:

- 2.12.1.1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, and maintain/improve their quality of life. Quality care refers to:
  - 2.12.1.1.1. Quality of physical health care, including primary and specialty care;
  - 2.12.1.1.2. Quality of behavioral health and substance abuse treatment focused on recovery, resiliency and rehabilitation;
  - 2.12.1.1.3. Quality of LTSS;
  - 2.12.1.1.4. Adequate access and availability to primary, behavioral health care, pharmacy, specialty health care, and LTSS Providers and services;
  - 2.12.1.1.5. Continuity and coordination of care across all care and services settings, and for transitions in care; and

- 2.12.1.1.6. Enrollee experience and access to high quality, coordinated and culturally competent clinical care and services, inclusive of LTSS across the care continuum.
- 2.12.1.2. Apply the principles of continuous quality improvement (CQI) to all aspects of the CICO's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:
  - 2.12.1.2.1. Quantitative and qualitative data collection and data-driven decision-making;
  - 2.12.1.2.2. Up-to-date evidence-based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence-based practice guidelines do not exist, consensus of professionals in the field;
  - 2.12.1.2.3. Feedback provided by Enrollees and network providers in the design, planning, and implementation of its CQI activities; and
  - 2.12.1.2.4. Issues identified by the CICO, SCDHHS and/or CMS.
- 2.12.1.3. Ensure that the quality improvement (QI) requirements of this Contract are applied to the delivery of primary and specialty health care services, behavioral health services, substance abuse treatment services, and LTSS.
- 2.12.2. QI Program Structure
  - 2.12.2.1. The CICO shall structure its QI program for the Demonstration separately from any of its existing Medicaid, or Medicare, or Commercial lines of business. For example, required measures for this Demonstration must be reported for the Demonstration population only. Integrating the Demonstration population into an existing line of business shall not be acceptable.
  - 2.12.2.2. The CICO shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the CICO's service delivery system. The QI program must be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The CICO's QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart D, Quality Assessment and Performance Improvement, 42 C.F.R. § 422, Subpart D Quality Improvement, and

shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.

2.12.3. The CICO shall:

- 2.12.3.1.1. Establish a set of QI functions and responsibilities that are clearly defined and that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion of QI initiatives in a competent and timely manner;
- 2.12.3.1.2. Ensure that such QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the CICO's service delivery system;
- 2.12.3.1.3. Seek the input of Providers and medical professionals representing the composition of the CICO's Provider Network in developing functions and activities;
- 2.12.3.1.4. Establish internal processes to ensure that the quality management activities for primary, specialty, and behavioral health services, and LTSS reflect utilization across the network and include all of the quality activities mentioned above in Sections 2.12.1 and 2.12.2 of this Contract and, in addition, the following elements:
  - 2.12.3.1.4.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Services (CAHPS), the Home and Community Based Services (HCBS) Experience Survey, the Health Outcomes Survey (HOS) and other measurement results in designing QI activities;

- 2.12.3.1.4.2. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications and appropriateness of care consistent with the utilization control requirements of 42 C.F.R. Part 456. Such process shall include the sampling method used which shall be proportionate to utilization by service type. The CICO shall submit its process for medical record reviews and the results of its medical record reviews to SCDHHS;
- 2.12.3.1.4.3. A process to measure Network Providers and Enrollees, at least annually, regarding their satisfaction with the CICO's Demonstration Plan. The CICO shall submit a survey plan to SCDHHS for approval and shall submit the results of the survey to SCDHHS and CMS in accordance with timeframes established by SCDHHS and CMS;
- 2.12.3.1.4.4. A process to measure clinical reviewer consistency in applying clinical criteria to UM activities, using inter-rater reliability measures;
- 2.12.3.1.4.5. A process for including Enrollees and their families in quality management activities, as evidenced by participation in Enrollee advisory boards; and
- 2.12.3.1.4.6. In collaboration with and as further directed by SCDHHS, develop a customized medical record review process to monitor the assessment for and provision of LTSS.
- 2.12.3.1.5. Have in place a written description of the QI Program that delineates the structure, goals, and objectives of the CICO's QI initiatives. Such description shall:
  - 2.12.3.1.5.1. Address all aspects of health care, including specific reference to behavioral health care and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care. Behavioral health and LTSS aspects of the QI program may be included in the QI description, or in a separate QI Plan referenced in the QI description;

- 2.12.3.1.5.2. Address the roles of the designated physician(s), behavioral health clinician(s), and LTSS Providers with respect to QI program;
- 2.12.3.1.5.3. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems; and
- 2.12.3.1.5.4. Include organization-wide policies and procedures that document processes through which the CICO ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and UM.
- 2.12.3.1.6. Submit, in accordance with established timeframes, to SCDHHS and CMS an annual QI Strategic Work Plan that shall include the following components or other components as directed by SCDHHS and CMS:
  - 2.12.3.1.6.1. Planned clinical and non-clinical initiatives;
  - 2.12.3.1.6.2. The objectives for planned clinical and non-clinical initiatives;
  - 2.12.3.1.6.3. The short and long term timeframes within which each clinical and non-clinical initiative's objectives are to be achieved;
  - 2.12.3.1.6.4. The individual(s) responsible for each clinical and non-clinical initiative;
  - 2.12.3.1.6.5. Any issues identified by the CICO, CMS, SCDHHS, Enrollees, and Providers, and how those issues are tracked and resolved over time;
  - 2.12.3.1.6.6. Program review process for formal evaluations that address the impact and effectiveness of clinical and non-clinical initiatives at least annually; and
  - 2.12.3.1.6.7. Process for correcting deficiencies.



- 2.12.3.1.7. Evaluate the results of QI initiatives at least annually, and submit the results of the evaluation to the CMT within established timeframes. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the CICO's assessment of the quality of physical and behavioral health care rendered, the effectiveness of LTSS services, and accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan; and
- 2.12.3.1.8. Maintain sufficient and qualified staff employed by the CICO to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g. education, training, and experience) for employees who will be responsible for QM. QI staff shall include:
  - 2.12.3.1.8.1. At least one designated physician, who shall be a medical director or associate medical director, at least one designated behavioral health clinician, and a professional with expertise in the assessment and delivery of LTSS with substantial involvement in the QI program;
  - 2.12.3.1.8.2. A qualified individual to serve as the Demonstration QI director who will be directly accountable to the CICO's South Carolina executive director and, in addition, if the CICO offers multiple products or services in multiple states, will have access to the CICO's executive leadership team. This individual shall be responsible for:
    - 2.12.3.1.8.2.1. Overseeing all QI activities related to Enrollees, ensuring compliance with all such activities, and maintaining accountability for the execution of, and performance in, all such activities;
    - 2.12.3.1.8.2.2. Maintaining an active role in the CICO's overall QI structure; and

2.12.3.1.8.2.3. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:

2.12.3.1.8.2.3. 1. Physical and behavioral health/substance abuse treatment care;

2.12.3.1.8.2.3. 2. Pharmacy management;

2.12.3.1.8.2.3. 3. Care management;

2.12.3.1.8.2.3. 4. LTSS;

2.12.3.1.8.2.3. 5. Financial;

2.12.3.1.8.2.3. 6. Statistical/analytical;

2.12.3.1.8.2.3. 7. Information systems;

2.12.3.1.8.2.3. 8. Marketing, publications;

2.12.3.1.8.2.3. 9. Enrollment; and

2.12.3.1.8.2.3. 10. Operations management;

2.12.3.1.9. Actively participate in, or assign staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by SCDHHS, or its designee, that may be attended by representatives of SCDHHS, a SCDHHS contractor, the CICO, and other entities, as appropriate; and

2.12.3.1.10. Serve as liaison to, and maintaining regular communication with, South Carolina QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

#### 2.12.4. QI Activities

2.12.4.1. The CICO shall engage in performance measurement and quality improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes

and Enrollee experience. This will include the ability to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

2.12.4.2. The CICO's QI program must include a health information system to collect, analyze, and report quality performance data as described in 42 C.F.R. §§ 438.242(a), 422.516(a) and 423.514.

2.12.4.3. Performance Measurement

2.12.4.3.1. CICO shall perform and report the quality and utilization measures identified by CMS and SCDHHS and in accordance with requirements in the MOU between CMS and the State of South Carolina on October 25, 2013, Figure 7-4 Core Quality Measures, and as amended in this Contract via Appendix K, and shall include, but are not limited to:

2.12.4.3.1.1. All HEDIS, HOS and CAHPS data, as well as all other measures specified in Appendix K. HEDIS, HOS and CAHPS must be reported consistent with Medicare requirements. All existing Part D metrics will be collected as well. Additional details, including technical specifications, will be provided in annual guidance by CMS and SCDHHS for the upcoming reporting year.

2.12.4.3.2. CICO shall not modify the reporting specifications methodology prescribed by CMS and SCDHHS without first obtaining CMS and SCDHHS's written approval. CICO must obtain an independent validation of its findings by a recognized entity, e.g., NCQA-certified auditor, as approved by CMS and SCDHHS. CMS and SCDHHS (or its designee) will perform an independent validation of at least a sample of CICO's findings.

2.12.4.3.3. CICO shall monitor other performance measures not specifically stated in the Contract that are required by CMS. SCDHHS will use its best efforts to notify CICO of new CMS requirements.

2.12.4.3.4. The CICO shall collect annual data and contribute to all Demonstration QI-related processes, as directed by SCDHHS and CMS, as follows:

- 2.12.4.3.4.1. Collect and submit to SCDHHS, CMS and/or CMS' CICOs, within the timeframes outlined in the Demonstration reporting requirements document, data for the measures specified in Appendix L;
- 2.12.4.3.4.2. Contribute to all applicable SCDHHS and CMS data quality assurance processes, which shall include, but not be limited to, responding, within the timeframes outlined in the Demonstration reporting requirements document, to data quality inadequacies identified by SCDHHS and rectifying those inadequacies, as directed by SCDHHS;
- 2.12.4.3.4.3. Contribute to SCDHHS and CMS data regarding the individual and aggregate performance of SCDHHS CICOs with respect to the noted measures; and
- 2.12.4.3.4.4. Contribute to SCDHHS processes culminating in the publication of any additional technical or other reports by SCDHHS related to the noted measures.
- 2.12.4.3.5. The CICO shall demonstrate how to utilize results of the measures specified in Appendix K in designing QI initiatives.
- 2.12.4.4. Enrollee Experience Surveys:
  - 2.12.4.4.1. The CICO shall conduct Enrollee experience survey activities, as directed by SCDHHS and/or CMS, as follows:
    - 2.12.4.4.1.1. Conduct, as directed by SCDHHS and CMS, an annual CAHPS survey, including the Persons with Mobility Impairment Supplemental Questions, using an approved CAHPS vendor;

- 2.12.4.4.1.2. Conduct, as directed by SCDHHS, a South Carolina participant experience survey for individuals utilizing HCBS during the prior calendar year. This shall require that individuals conducting such survey are appropriately and comprehensively trained, culturally competent, and knowledgeable of the population being surveyed;
- 2.12.4.4.1.3. Contribute, as directed by SCDHHS and CMS, to data quality assurance processes, including responding, within the timeframes established by CMS and SCDHHS, to data quality inadequacies identified by SCDHHS and CMS and rectifying those inadequacies, as directed by SCDHHS and CMS;
- 2.12.4.4.1.4. Contribute, as directed by SCDHHS, to processes culminating in the development of an annual report by SCDHHS regarding the individual and aggregate Enrollee experience survey performance of SCDHHS-contracted CICOs; and
- 2.12.4.4.1.5. The CICO shall demonstrate best efforts to utilize Enrollee experience survey results in designing QI initiatives.

## 2.12.5. QI Project Requirements

- 2.12.5.1.1. The CICO shall implement and adhere to all processes relating to the QI project requirements, as directed by SCDHHS and CMS, as follows:
  - 2.12.5.1.1.1. During the Enrollment year and annually thereafter, CICO will identify applicable representatives to serve on a quality collaborative with SCDHHS and its External Quality Review Organization (EQRO). This collaborative will determine QI initiatives to begin in Year 1 of the Demonstration and annually thereafter;

- 2.12.5.1.1.2. In accordance with 42 C.F.R. §438.240 (d) and 42 C.F.R. § 422.152 (d), collect information and data in accordance with QI project requirement specifications for its Enrollees; using the format and submission guidelines specified by SCDHHS and CMS in annual guidance provided for the upcoming contract year;
- 2.12.5.1.1.3. Implement the QI project requirements, in a culturally competent manner, to achieve objectives as specified by SCDHHS and CMS;
- 2.12.5.1.1.4. Evaluate the effectiveness of QI interventions;
- 2.12.5.1.1.5. Plan and initiate processes to sustain achievements and continue improvements;
- 2.12.5.1.1.6. Submit to SCDHHS and CMS, comprehensive written reports, using the format, submission guidelines and frequency specified by SCDHHS and CMS. Such reports shall include information regarding progress on QI project requirements, barriers encountered and new knowledge gained. As directed by SCDHHS and CMS, the CICO shall present this information to SCDHHS and CMS at the end of the QI requirement project cycle as determined by SCDHHS and CMS; and
- 2.12.5.1.1.7. In accordance with 42 C.F.R. § 422.152 (c), develop a chronic care improvement program (CCIP) and establish criteria for participation in the program. The CCIP must be relevant to and target the CICO's plan population. Although the CICO has the flexibility to choose the design of their CCIPs, SCDHHS and CMS may require them to address specific topic areas.

2.12.5.2. CMS-Specified Performance Measurement and Performance Improvement Projects

- 2.12.5.2.1. The CICO shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 C.F.R. § 438.240(a)(2).

2.12.6. External Quality Review (EQR) Activities

- 2.12.6.1. The CICO shall take all steps necessary to support the EQRO contracted by SCDHHS and the QIO to conduct EQR activities, in accordance with 42 C.F.R. § 438.358 and 42 C.F.R. § 422.153. EQR activities shall include, but are not limited to:
  - 2.12.6.1.1. Annual validation of performance measures reported to SCDHHS, as directed by SCDHHS, or calculated by SCDHHS;
  - 2.12.6.1.2. Annual validation of quality improvement projects required by SCDHHS and CMS; and
  - 2.12.6.1.3. At least once every three (3) years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, and at the direction of SCDHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees. The CICO shall take all steps necessary to support the EQRO and QIO in conducting EQR activities including, but not limited to:
    - 2.12.6.1.3.1. Designating a qualified individual to serve as project director for each EQR activity who shall, at a minimum:
      - 2.12.6.1.3.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;
      - 2.12.6.1.3.1.2. Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO, QIO, SCDHHS and/or CMS staff in a timely manner;
      - 2.12.6.1.3.1.3. Serve as the liaison to the EQRO, QIO, SCDHHS and CMS and answer questions or coordinate responses to questions from the EQRO, QIO, CMS and SCDHHS in a timely manner; and
      - 2.12.6.1.3.1.4. Ensure timely access to information systems, data, and other resources, as necessary for the EQRO and/or QIO to perform the EQR activity and as requested by the EQRO, QIO, CMS or SCDHHS.

- 2.12.6.1.3.2. Maintaining data and other documentation necessary for completion of EQR activities specified above. The CICO shall maintain such documentation for a minimum of ten (10) years;
- 2.12.6.1.3.3. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or SCDHHS;
- 2.12.6.1.4. Participating in CICO-specific and cross-CICO meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and SCDHHS;
- 2.12.6.1.5. Implementing actions, as directed by SCDHHS and/or CMS, to address recommendations for QI made by the EQRO or QIO, and sharing outcomes and results of such activities with the EQRO or QIO, SCDHHS, and CMS in subsequent years; and
- 2.12.6.1.6. Participating in any other activities deemed necessary by the EQRO and/or QIO and approved by SCDHHS and CMS.

#### 2.12.7. QI for Utilization Management Activities

- 2.12.7.1. The CICO shall utilize QI to ensure that it maintains a well-structured UM program that supports the application of fair, impartial and consistent UM determinations.
- 2.12.7.2. The QI activities for the UM program shall include:
  - 2.12.7.2.1. Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue Medically Necessary Services;
  - 2.12.7.2.2. At least one (1) designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, at least one (1) designated behavioral health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, and a professional with expertise in the assessment and delivery of LTSS representative of the CICO or subcontractor, with substantial involvement in the UM program; and



2.12.7.2.3. A written document that delineates the structure, goals, and objectives of the UM program and that describes how the CICO utilizes QI processes to support its UM program. Such document may be included in the QI description, or in a separate document, and shall address how the UM program fits within the QI structure, including how the CICO collects UM information and uses it for QI activities.

## 2.12.8. Clinical Practice Guidelines

2.12.8.1. The CICO shall adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that:

2.12.8.1.1.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals or professionals with expertise in the assessment and delivery of LTSS in the relevant field, community-based support services or the CICO's approved behavioral health performance specifications and clinical criteria;

2.12.8.1.1.2. Stem from recognized organizations that develop or promulgate evidence-based clinical practice guidelines, or are developed with involvement of board-certified Providers from appropriate specialties or professionals with expertise in the assessment and delivery of LTSS;

2.12.8.1.1.3. Do not contradict existing South Carolina-promulgated regulations or requirements as published by the Departments of Social Services, Health and Environmental Control, Mental Health, Disabilities and Special Needs, or other state agencies;

2.12.8.1.1.4. Prior to adoption, have been reviewed by the CICO's medical director, as well as other CICO practitioners and Network Providers, as appropriate; and

2.12.8.1.1.5. Are reviewed and updated, as appropriate, or at least every two (2) years.

2.12.8.2. Guidelines shall be reviewed and revised, as appropriate based on changes in national guidelines, or changes in valid and reliable clinical

evidence, or consensus of health care and LTSS professionals and providers;

- 2.12.8.3. For guidelines that have been in effect two (2) years or longer, the CICO must document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly;
- 2.12.8.4. Disseminate, in a timely manner, the clinical guidelines to all new Network Providers, to all affected Providers, upon adoption and revision, and, upon request, to Enrollees and Eligible Beneficiaries. The CICO shall make the clinical and practice guidelines available via the CICO's web site. The CICO shall notify Providers of the availability and location of the guidelines, and shall notify Providers whenever changes are made;
- 2.12.8.5. Establish explicit processes for monitoring the consistent application of clinical and practice guidelines across UM decisions and Enrollee education, coverage of services; and
- 2.12.8.6. Submit to SCDHHS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the CICO, upon request.

#### 2.12.9. QI Workgroups

- 2.12.9.1. As directed by SCDHHS, the CICO shall actively participate in QI workgroups that are led by SCDHHS, including any quality management workgroups or activities, attended by representatives of SCDHHS, SCDHHS-CICOs, and other entities, as appropriate, and that are designed to support QI activities and to provide a forum for discussing relevant issues. Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup.

#### 2.12.9.2. SCDHHS Directed Performance Incentive Program

- 2.12.9.2.1. SCDHHS and CMS will require that the CICO meet specific performance requirements in order to receive payment of withheld amounts over the course of the Contract. These withhold measures are detailed in Section 4.4.4.
- 2.12.9.2.2. In order to receive any withhold payments, the CICO shall comply with all SCDHHS and CMS withhold measure requirements while maintaining satisfactory performance on all other Contract requirements.

### 2.12.9.3. Enrollee Incentives

- 2.12.9.3.1. The CICO may provide Enrollee incentives, as appropriate, to promote engagement in specific behaviors
- 2.12.9.3.2. There must be a reasonable connection between the incentivized behaviors and Enrollees' care goals or the medical and support services provided to Enrollees. For example, incentivized behaviors may include, but are not limited to, receiving recommended clinical screenings and preventive services, visiting a PCP regularly, participation in CICO wellness initiatives, adherence to a treatment regime, adherence to a drug regime, adherence to a care plan, or management of a chronic disease or condition.
- 2.12.9.3.3. There must also be a reasonable connection between the incentives offered and the Enrollees' care goals or the medical and support services provided to Enrollees. For example, incentives may include, but are not limited to, first aid supplies, utilities, public transportation, thermometers, environmental modifications and home repairs, personal care services, including respite, and home goods that support independence, such as microwaves. CICOs may not offer incentives that are unrelated to Enrollee care or support, such as theater tickets or beauty products.
- 2.12.9.3.4. The CICO must monitor the effectiveness of such Enrollee incentives in promoting the incentivized behaviors. The CICO can use this monitoring to revise the incentive program during the annual Plan Benefit Package submission. Revisions to incentive programs must take into consideration Enrollee feedback on the existing program and/or proposed changes to the program;
- 2.12.9.3.5. The CICO must monitor its incentive programs for fraud, waste, and abuse committed by, but not limited to, providers and Enrollees.
- 2.12.9.3.6. The nominal value of each in-kind Enrollee incentive cannot exceed twenty-five dollars (\$25).

- 2.12.9.3.7. Enrollees may not receive incentives valued in excess of \$1000 per calendar year. This limit applies to beneficiaries who disenroll (or are disenrolled from) the CICO and re-enroll with the same CICO within the same calendar year.
- 2.12.9.3.8. Enrollee incentive programs must be offered to all current enrollees, and if used in marketing materials must be marketed to all eligible beneficiaries, without discrimination based on race, national origin, gender, disability, chronic disease, whether a person resides or receives services in an institutional setting, or other prohibited basis. Further, when marketing Enrollee incentive programs to potential enrollees, plans must do so in conjunction with Plan benefits.
  - 2.12.9.3.8.1.1. CICOs may include some incentives for Enrollees to receive services that are only available to males or females, such as prostate exams or mammograms.
- 2.12.9.3.9. At the direction of SCDHHS, CICOs must submit to SCDHHS ad hoc report information relating to planned and implemented Enrollee incentives and ensure that all such Enrollee incentives comply with all applicable Medicare-Medicaid marketing guidance, as well as state and federal laws. SCDHHS may also request the CICO to provide reports on enrollee incentive programs at regular intervals if SCDHHS deems doing so necessary to monitor the effectiveness or the integrity of such programs.
- 2.12.9.3.10. CMS and/or SCDHHS may require changes to the CICO's enrollee incentive program(s) if the programs are found to be grossly inconsistent with the parameters outlined this section, in violation of any applicable guidance, or a source of fraud, waste, or abuse.
- 2.12.9.3.11. Enrollee Accounts

- 2.12.9.3.11.1. CICOs may, at their discretion, establish accounts to be used and be directed by the Enrollee or designee to purchase non-covered services. Accounts are considered Enrollee incentive programs and are therefore subject to all the program limitations outlined in Sections 2.12.9.3.1 through 2.12.9.3.10 with the exception of the nominal per-incentive and annual incentive limits in Sections 2.12.9.3.6 and 2.12.9.3.7.
- 2.12.9.3.11.2. CICOs may, at their discretion, set parameters regarding reward amounts, and frequency limitations.
- 2.12.9.3.11.3. Such accounts should be designed to provide Enrollees with the flexibility to supplement their covered care with services and/or supports that will help them to maintain or improve their conditions. Accounts should also promote Enrollee engagement and self-determination.
- 2.12.9.3.11.4. Accounts must allow Enrollees to purchase only non-covered services or supports that contribute to an Enrollee's overall health. Non-covered services and supports include medical or LTSS benefits that are not covered by the plan, services in excess of the covered amounts, and other supportive non-medical services. For example, CICOs could allow enrollees to apply the account funds toward services and items such as, but not limited to, dentures, nursing facility personal needs allowances, personal assistance with activities of daily living, or home modifications to make the Enrollee's personal residence safer or more accessible.

- 2.12.9.3.11.5. Accounts cannot be used to pay for covered services, nor may CICOs allow Enrollees to apply the account funds toward items or activities solely intended for entertainment, home improvements unrelated to or unnecessary for the Enrollee's condition, or items or services intended primarily for anyone other than Enrollee. For example, an Enrollee could not use the account funds to contribute upgrades to an institutional setting that would typically be the responsibility of the facility or for home modifications intended to accommodate a co-resident's mobility needs. Accounts should not be used for the purchase of entertainment items such as books, televisions, or gaming systems. This section is not an exhaustive list of prohibited services or items.
- 2.12.9.3.11.6. The CICO is responsible for designing and overseeing the accounts such the accounts are not subject to fraud, waste, or abuse by any party while ensuring that Enrollees have the independence to control their own accounts.
- 2.12.9.3.11.7. CICOs, through their care coordinators or member services department, must provide Enrollees with information or assistance with which to find reputable service providers when the Enrollee seeks to use the account to purchase services from providers outside the CICO's network of clinical or LTSS providers. For example, if the CICO permits Enrollees to use the accounts for home modifications, then the CICO must help Enrollees to find professional service providers who meet industry qualifications. CICOs may provide Enrollees with lists of pre-screened service providers and may prohibit Enrollees from using providers known for fraud, waste, abuse, lack of professional credentials, or other quality-related concerns.
- 2.12.9.3.11.8. Accounts must be overseen by a financial intermediary that provides counseling and guidance to Enrollees to support both independence and program integrity.

#### 2.12.9.4. Behavioral Health Services Outcomes

- 2.12.9.4.1. The CICO shall require behavioral health Providers to measure and collect clinical outcomes data, to incorporate that data in treatment data available to the CICO, upon request;
- 2.12.9.4.2. The CICO's behavioral health Provider Contracts shall require the Provider to make available behavioral health clinical assessment and outcomes data for quality management and network management purposes;
- 2.12.9.4.3. The CICO shall use outcome measures based on behavioral health care best practices. As directed by SCDHHS, the CICO shall collaborate with behavioral health Providers to develop outcome measures that are specific to each behavioral health service type. Such outcome measures may include:
  - 2.12.9.4.3.1. Recidivism;
  - 2.12.9.4.3.2. Adverse occurrences;
  - 2.12.9.4.3.3. Treatment drop-out;
  - 2.12.9.4.3.4. Rate of utilization of community based services compared to inpatient services;
  - 2.12.9.4.3.5. Length of time between admissions; and
  - 2.12.9.4.3.6. Treatment goals achieved.

#### 2.12.9.5. External Audit/Accreditation Results

- 2.12.9.5.1. The CICO shall inform SCDHHS if it is nationally accredited or if it has sought and been denied such accreditation, and submit to SCDHHS, at SCDHHS' direction, a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any.

#### 2.12.9.6. Health Information System

- 2.12.9.6.1. The CICO shall maintain a health information system or systems consistent with the requirements established in the Contract and that supports all aspects of the QI Program.

#### 2.12.10. Evaluation Activities

- 2.12.10.1. SCDHHS, CMS, and its designated agent(s) will conduct periodic evaluations of the Demonstration over time from multiple perspectives using both quantitative and qualitative methods.
- 2.12.10.2. The evaluations will be used for program improvement purposes and to assess the Demonstration's overall impact on various outcomes including (but not limited to) Enrollment/disenrollment patterns, Enrollee access and quality of care experiences, utilization and costs by service type (e.g., inpatient, outpatient, home health, prescription drugs, nursing facility, and home and community based waiver), and program staff and Provider experiences.
- 2.12.10.3. As such, the evaluations will include surveys, site visits, analysis of claims and Encounter Data, focus groups, key informant interviews, and document reviews. The CICO shall participate in evaluation activities as directed by CMS and/or SCDHHS and provide information or data upon request.

## 2.13. Marketing, Outreach, and Enrollee Communications Standards

### 2.13.1. Requirements, General

- 2.13.1.1. The CICO is subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social Security Act; 42 CFR §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, and §423.2260 et. seq.; and the Medicare Marketing Guidelines (found at <http://cms.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html>), with the following exceptions or modifications:
  - 2.13.1.1.1. The CICO must refer to SCDHHS' authorized agent any Enrollees and Eligible Beneficiaries who inquire about Demonstration eligibility or Enrollment, although the CICO may provide Enrollees and Eligible Beneficiaries with factual information about the CICO's plan and its benefits prior to referring a request regarding eligibility or Enrollment to the SCDHHS authorized agent;
  - 2.13.1.1.2. The CICO must make available to CMS and SCDHHS, upon request, current schedules of all educational events conducted by the CICO to provide information to Enrollees or Eligible Beneficiaries;



- 2.13.1.1.3. The CICO must distribute all materials to its entire service area; and must convene all educational and marketing/sales events at sites within the CICO's Service Area that are physically accessible to all Enrollees or Eligible Beneficiaries, including persons with disabilities and persons using public transportation.
- 2.13.1.1.4. The CICO may not offer financial or other incentives, including private insurance, to induce Enrollees or Eligible Beneficiaries to enroll with the CICO or to refer a friend, neighbor, or other person to enroll with the CICO;
- 2.13.1.1.5. The CICO may not directly or indirectly conduct door-to-door, telephone, or other unsolicited contacts;
- 2.13.1.1.6. The CICO's sales agents are not permitted to conduct unsolicited personal/individual appointments;
- 2.13.1.1.7. An individual appointment must only be set up at the request of the Enrollee or his/her authorized representative. A CICO can offer an individual appointment to an Enrollee that has contacted the CICO to request assistance or information. However, the CICO is prohibited from making unsolicited offers of individual appointments; and
- 2.13.1.1.8. The CICO must make reasonable efforts to conduct an appointment in the Enrollee's preferred location. The CICO cannot require that an individual appointment occur in an Enrollee's home.
- 2.13.1.1.9. The CICO may not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that:
  - 2.13.1.1.9.1. The Enrollee or Eligible Beneficiary must enroll with the CICO in order to obtain benefits or in order not to lose benefits; and
  - 2.13.1.1.9.2. The CICO is endorsed by CMS, Medicare, Medicaid, the federal government, SCDHHS or similar entity.
- 2.13.1.1.10. Annually, the CICO shall present its marketing plan to SCDHHS for review and approval.

## 2.13.2. Requirements for Materials

2.13.2.1. The CICO's Marketing, Outreach, and Enrollee Communications materials must be:

2.13.2.1.1. Made available in Alternative Formats, upon request and as needed to assure effective communication for blind and vision-impaired Enrollees;

2.13.2.1.2. Provided in a manner, format and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments;

2.13.2.1.3. Translated into Prevalent Languages for all vital materials, as specified in the Medicare-Medicaid Marketing Guidelines and annual guidance to CICOs on specific translation requirements for their service areas;

2.13.2.1.3.1. Prevalent Languages are Spanish and those that meet the five (5) percent threshold for language translation.

2.13.2.1.4. Mailed with a multi-language insert that indicates that the Enrollee can access free interpreter services to answer any questions about the plan. This message shall be written in the languages required in the Medicare Marketing Guidelines' provisions on the multi-language insert and any additional languages that meet the more stringent of either: (1) Medicare's five (5) percent threshold for language translation; or (2) SCDHHS' Prevalent Language requirements.

2.13.2.1.5. Distributed to the CICO's entire Service Area as specified in Appendix J of this Contract.

## 2.13.3. Requirements for the Submission, Review, and Approval of Materials

2.13.3.1. The CICO must receive prior approval of all marketing and Enrollee communications materials in categories of materials that CMS and SCDHHS require to be prospectively reviewed. CICO materials may be designated as eligible for the File & Use process, as described in 42 C.F.R. §422.2262(b) and §423.2262(b), and will therefore be exempt from prospective review and approval by both CMS and SCDHHS. CMS and SCDHHS may agree to defer to one or the other party for review of certain types of marketing and Enrollee communications, as

agreed in advance by both parties. CICOs must submit all materials that are consistent with the definition of marketing materials at 42 C.F.R. § 422.2260, whether prospectively reviewed or not, via the CMS HPMS Marketing Module.

2.13.3.2. CMS and SCDHHS may conduct additional types of review of CICO marketing, outreach, and Enrollee Communications activities, including, but not limited to:

2.13.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits.

2.13.3.2.2. Random review of actual marketing, outreach, and Enrollee Communications pieces as they are used in the marketplace.

2.13.3.2.3. “For cause” review of materials and activities when complaints are made by any source, and CMS or SCDHHS determine it is appropriate to investigate.

2.13.3.2.4. “Secret shopper” activities where CMS or SCDHHS request CICO materials, such as Enrollment packets.

2.13.3.3. Beginning of Marketing, Outreach and Enrollee Communications Activity

2.13.3.3.1. The CICO may not begin Marketing, Outreach, and Enrollee Communications activities to new Enrollees more than ninety (90) calendar days prior to the effective date of Enrollment for the Contract year.

2.13.3.3.2. In addition, for the first year of the Demonstration, the CICO may not begin marketing activity until the CICO has entered into this Contract, passed the joint CMS-South Carolina Readiness Review, and is connected to CMS Enrollment and payment systems such that the CICO is able to receive payment and Enrollments.

2.13.4. Requirements for Dissemination of Materials

2.13.4.1. Consistent with the timelines specified in the Medicare-Medicaid marketing guidance, the CICO must provide Enrollees with the following materials which, with the exception of the materials specified in Section 2.13.4.1.3 and Section 2.13.4.1.4 below, must also be provided annually thereafter:

- 2.13.4.1.1. An Evidence of Coverage (EOC)/Enrollee Handbook document that is consistent with the requirements at 42 C.F.R. §§438.10, 422.411, and 423.128; includes information about all Covered Services, as outlined below, and that uses the model document developed by CMS and SCDHHS.
  - 2.13.4.1.1.1. Enrollee rights (see Appendix D);
  - 2.13.4.1.1.2. An explanation of the Enrollee Medical Record and the process by which clinical information, including diagnostic and medication information, will be available to key caregivers;
  - 2.13.4.1.1.3. How to obtain a copy of the Enrollee's centralized Enrollee Medical Record;
  - 2.13.4.1.1.4. How to obtain access to specialty, behavioral health, pharmacy and LTSS Providers;
  - 2.13.4.1.1.5. How to obtain services and prescription drugs for Emergency Medical Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area; including:
  - 2.13.4.1.1.6. What constitutes Emergency Medical Condition, Emergency Services, and Post-stabilization Services, with reference to the definitions in 42 C.F.R. § 438.114(a);
  - 2.13.4.1.1.7. The fact that prior authorization is not required for Emergency Services;
  - 2.13.4.1.1.8. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone system or its local equivalent;
  - 2.13.4.1.1.9. The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the Contract;
  - 2.13.4.1.1.10. That the Enrollee has a right to use any hospital or other setting for emergency care; and
  - 2.13.4.1.1.11. The Post-stabilization Care Services rules at 42 C.F.R. §422.113(c).

- 2.13.4.1.1.12. Information about advance directives (at a minimum those required in 42 C.F.R. §§ 489.102 and 422.128), including
  - 2.13.4.1.1.12.1. Enrollee rights under the law of the State of South Carolina;
  - 2.13.4.1.1.12.2. The CICO's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience;
  - 2.13.4.1.1.12.3. That complaints concerning noncompliance with the advance directive requirements may be filed with SCDHHS;
  - 2.13.4.1.1.12.4. Designating a health care proxy, and other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee; and
  - 2.13.4.1.1.12.5. The CICO must update materials to reflect any changes in state law as soon as possible, but no later than ninety (90) calendar days after the effective date of change.
- 2.13.4.1.1.13. How to obtain assistance from ESRs;
- 2.13.4.1.1.14. How to file Grievances and Internal and External Appeals, including:
- 2.13.4.1.1.15. Grievance, Appeal and State Fair Hearing procedures and timeframes;
- 2.13.4.1.1.16. Toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone for expedited external Appeals only (only expedited Appeals may be received telephonically for external Appeals through State Fair Hearing Process);

- 2.13.4.1.1.17. If the Enrollee files an Appeal or a request for State Fair Hearing within the timeframes specified for filing, the Enrollee may request that benefits continue at the plan level; the Enrollee may be required to pay to CICO the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee; and
  - 2.13.4.1.1.18. How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;
  - 2.13.4.1.1.19. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as SCDHHS or CMS may identify, including an Ombudsman;
  - 2.13.4.1.1.20. The extent to which, and how Enrollees may obtain benefits, including family planning services, from out-of-network Providers;
  - 2.13.4.1.1.21. How and where to access any benefits that are available under the South Carolina Medicaid State Plan or applicable waivers but are not covered under the Contract;
  - 2.13.4.1.1.22. How to change Providers; and
  - 2.13.4.1.1.23. How to disenroll voluntarily.
- 2.13.4.1.2. A Summary of Benefits (SB) that contains a concise description of the important aspects of enrolling in the CICO's plan, as well as the benefits offered under the CICO's plan, including any cost sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and is consistent with the model document developed by CMS and SCDHHS. The SB should provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled. For new Enrollees, the SB is required only for individuals enrolled through Passive Enrollment. For current Enrollees, the SB must be sent with the Annual Notice of Change (ANOC) as described in the Medicare-Medicaid marketing guidance.

- 2.13.4.1.3. A combined Provider and Pharmacy Directory that is consistent with the requirements in Section 2.7.9.
- 2.13.4.1.4. A single identification (ID) card for accessing all covered services under the plan that uses the model document developed by CMS and SCDHHS;
- 2.13.4.1.5. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and SCDHHS' outpatient prescription drug benefit and that uses the model document developed by CMS and SCDHHS.
- 2.13.4.1.6. The procedures for an Enrollee to change CICOs or to Opt-Out of the Demonstration.
- 2.13.4.1.7. The CICO must provide the following materials to current Enrollees on an ongoing basis:
  - 2.13.4.1.7.1. An Annual Notice of Change (ANOC) that summarizes all major changes to the CICO's covered benefits from one Contract year to the next, and that uses the model document developed by CMS and the SCDHHS;
  - 2.13.4.1.7.2. A combined Provider and Pharmacy Directory as frequently as specified in Section 2.13.5; and as needed to replace old versions or upon an Enrollee's request; and
  - 2.13.4.1.7.3. A single ID card for accessing all Covered Services under the plan.
- 2.13.4.1.8. The CICO must provide all Medicare Part D required notices, with the exception of the late enrollment penalty notices and the creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the late LIS Rider required under Chapter 13 of the Prescription Drug Benefit Manual.
- 2.13.4.1.9. Consistent with the requirement at 42 C.F.R. § 423.120(b)(5), the CICO must provide Enrollees with at least sixty (60) days advance notice regarding changes to the comprehensive, integrated formulary.

2.13.4.1.10. The CICO must ensure that all information provided to Enrollees and Eligible Beneficiaries (and families when appropriate) is provided in a manner and format that is easily understood and that is:

2.13.4.1.10.1. Made available in large print (at least sixteen (16) point font) to Enrollees as an Alternative Format, upon request;

2.13.4.1.10.2. For vital materials, available in Spanish and any languages that meet the more stringent of either: (1) Medicare's five (5) percent threshold for language translation; or (2) SCDHHS' Prevalent Language requirements, as provided for in the Medicare-Medicaid marketing guidance.

2.13.4.1.10.3. Written with cultural sensitivity and at or below a sixth (6<sup>th</sup>) grade reading level; and

2.13.4.1.10.4. Available in Alternative Formats, according to the needs of Enrollees and Eligible Beneficiaries including Braille, oral interpretation services in non-English languages, as specified in Section 2.13.2 of this Contract; audiotape; American Sign Language video clips, and other alternative media, as requested.

2.13.4.2. The CICO will provide the following information upon the Enrollee's request:

2.13.4.2.1. Information on the structure and operation of the CICO; and

2.13.4.2.2. Physician incentive plans as set forth in 42 C.F.R. § 438.6(h).

2.13.4.2.2.1.

2.13.5. Requirements for the Provider and Pharmacy Network Directory

2.13.5.1. Maintenance and Distribution: The CICO must:

2.13.5.1.1. Maintain a combined Provider and Pharmacy Network Directory that uses the model document developed by CMS and SCDHHS;



- 2.13.5.1.2. Provide either a copy or information about how to access a copy, as specified in the Medicare-Medicaid marketing guidance, to all new Enrollees at the time of Enrollment and, upon request, to both new and continuing Enrollees;
  - 2.13.5.1.3. Provide a copy or information about how to access a copy, as specified in the Medicare-Medicaid marketing guidance, to continuing Enrollees at least every three (3) years after the time of Enrollment, unless there is a significant change to the network, in which case the CICO must send a special mailing of an updated directory or information about the network change and how to access a copy, as specified in the Medicare-Medicaid marketing guidance immediately;
  - 2.13.5.1.4. Ensure an up-to-date copy is available on the CICO's website, consistent with the requirements at 42 C.F.R. §§ 422.111(h) and 423.128(d);
  - 2.13.5.1.5. Consistent with 42 C.F.R. § 422.111(e), make a good faith effort to provide written notice of termination of a contracted Provider or pharmacy at least thirty (30) calendar days before the termination effective date to all Enrollees who regularly use the Provider or pharmacy's services; if a Contract termination involves a primary care professional, all Enrollees who are patients of that primary care professional must be notified; and
  - 2.13.5.1.6. Include written and oral offers of such Provider and Pharmacy Directory in its outreach and orientation sessions for new Enrollees.
- 2.13.5.2. Content of Provider and Pharmacy Directory
- 2.13.5.2.1. The Provider and Pharmacy Directory must include, at a minimum, the following information for all Providers/pharmacies in the CICO's Provider/Pharmacy Network:
    - 2.13.5.2.1.1. The names, addresses, and telephone numbers of all current Network Providers and pharmacies.
    - 2.13.5.2.1.2. Network Providers with areas of special experience, skills and training.

- 2.13.5.2.1.3. Office hours for each Network Provider, including the names of any Network Provider sites open after 5:00 p.m. (EST) weekdays and on weekends;
- 2.13.5.2.1.4. The cultural and linguistic capabilities of Network Providers, including languages spoken by the Network Provider or by skilled medical interpreter at the Network Provider's site;
- 2.13.5.2.1.5. Network Provider licensing information;
- 2.13.5.2.1.6. Whether the Provider is accepting new patients;
- 2.13.5.2.1.7. Whether the Network Provider can be accessed by public transportation;
- 2.13.5.2.1.8. Languages other than English spoken by providers or by skilled medical interpreters at the provider's site, including American Sign Language, and whether translation services are available;
- 2.13.5.2.1.9. For behavioral health Providers, qualifications and licensing information, and special experience, skills, and training (i.e., trauma, child welfare, substance use);
- 2.13.5.2.1.10. For pharmacies, instructions for the Enrollee to contact the CICO's toll-free Enrollee Services telephone line (as described in Section 2.9) for assistance in finding a convenient pharmacy; and
- 2.13.5.2.1.11. A description of the roles of the MT and the process by which Enrollees select and change PCPs.

## 2.14. Financial Requirements

### 2.14.1. Financial Viability

- 2.14.1.1. Consistent with Section 1903 (m) of the Social Security Act, and regulations found at 42 CFR § 422.402, and 42 CFR § 438.116, the CICO shall meet all state and federal financial soundness requirements. These include:

- 2.14.1.1.1. The CICO must provide assurances that its provision against the risk of insolvency is adequate to ensure that its Enrollees will not be liable for the entity's debts, if the entity becomes insolvent.
- 2.14.1.1.2. The CICO must produce adequate documentation satisfying SCDHHS that it has met its solvency requirements.
- 2.14.1.1.3. The CICO must also maintain reserves to remain solvent for a forty-five (45) day period, and provide satisfactory evidence to SCDHHS of such reserves.
- 2.14.1.1.4. The CICO shall secure and maintain during the life of this Contract a blanket fidelity bond from a company doing business in the State of South Carolina on all personnel in its employment. The bond shall be issued in accordance with South Carolina Department of Insurance (SCDOI) requirements, per occurrence. Said bond shall protect SCDHHS from any losses sustained through any fraudulent or dishonest act or acts committed by any employees, agents, assigns, independent contractors and anyone else acting on behalf of the CICO and First Tier, Downstream or Related Entities.
- 2.14.1.1.5. The CICO shall establish an insolvency protection account as required by the SCDOI and federal law. The CICO shall provide continuing proof of solvency, in accordance with S.C. Code Ann. § 38-33-130 (Supp. 2000, as amended) and 25A S.C. Code Ann. Regs. §69-22 (Supp. 2000, as amended). The CICO shall submit proof of insolvency protection account approved by SCDOI prior to execution of this Contract and initial Enrollment.
- 2.14.1.1.6. The CICO shall maintain the required amount of working capital pursuant to S.C. Code Ann. §38-33-100, (Supp. 2000, as amended), and 25A S.C. Code Ann. Regs. §69-22 (Supp. 2000, as amended), as amended and approved by SCDOI.

2.14.1.1.7. The CICO shall maintain at all times surplus account reserves as required by the SCDOI and state law. In the event that the CICO's surplus falls below any applicable statutory requirements, SCDHHS shall prohibit the CICO from engaging in Enrollment activities, shall cease to process new Enrollments and shall not renew this Contract until the required balance is achieved, and certified by the SCDOI.

2.14.1.1.8. Pursuant to Title 38, Chapter 12 of the South Carolina Code of Laws, securities appearing in Schedule D of the CICO's most recent annual statement must be valued by the NAIC Securities Valuation Office, or proper evidence must be provided to this SCDHHS to indicate that those securities not listed have been submitted to the NAIC Securities Valuation Office for valuation or that they are exempt from filing with the NAIC Securities Valuation Office before the application is submitted to this Department. The CICO must provide a statement indicating that the securities have been valued by, submitted for valuation to, or are exempt from valuation by the NAIC Securities Valuation Office with supporting documentation.

#### 2.14.2. Other Financial Requirements

2.14.2.1. The CICO must cover continuation of services to Enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

#### 2.15. Data Submissions, Reporting Requirements, and Survey

##### 2.15.1. General Requirements for Data

2.15.1.1. The CICO must provide and require its First Tier, Downstream and Related Entities to provide:

2.15.1.1.1. All information CMS and SCDHHS require under the Contract related to the performance of the CICO's responsibilities, including non-medical information for the purposes of research and evaluation;

2.15.1.1.2. Any information CMS and SCDHHS require to comply with all applicable federal or state laws and regulations; and

- 2.15.1.1.3. Any information CMS or SCDHHS require for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Complaints and Appeals and Enrollment/disenrollment rates.

## 2.15.2. General Reporting Requirements

### 2.15.2.1. The CICO must:

- 2.15.2.1.1. Submit to SCDHHS applicable reporting requirements in compliance with this Contract;
- 2.15.2.1.2. Submit to CMS applicable Medicare reporting requirements in compliance with 42 C.F.R. §§ 422.516, § 423.514 and § 438 et. seq.
- 2.15.2.1.3. Submit to CMS all applicable CICO reporting requirements;
- 2.15.2.1.4. Submit to CMS and SCDHHS all required reports and data in accordance with the specifications, templates and timeframes described in this Contract;
- 2.15.2.1.5. Report HEDIS, HOS, and CAHPS data, as well as measures related to LTSS. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements for HEDIS, plus additional Medicaid measures required by SCDHHS. All existing Part D metrics will be collected as well. Such measures shall include a combined set of core measures that the CICO must report to CMS and SCDHHS;
- 2.15.2.1.6. Upon request, submit to CMS and SCDHHS any internal reports that the CICO uses for internal management. Such reports shall include, but not be limited to, internal reports that analyze the medical/loss ratio, financial stability, or other areas where standard compliance reports indicate a problem in performance;
- 2.15.2.1.7. Pursuant to 42 C.F.R. § 438.6(f)(2)(ii), comply with any reporting requirements on Provider Preventable Conditions in the form and frequency as may be specified by SCDHHS; and

- 2.15.2.1.8. Provide to CMS and SCDHHS, in a form and format approved by CMS and SCDHHS and in accordance with the timeframes established by CMS and SCDHHS, all reports, data or other information CMS and SCDHHS determine are necessary for compliance with provisions of the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance.
- 2.15.2.1.9. Submit at the request of CMS or SCDHHS additional ad hoc or periodic reports or analyses of data related to the Contract.

### 2.15.3. Information Management and Information Systems

#### 2.15.3.1. General: the CICO shall:

- 2.15.3.1.1. Maintain Information Systems (Systems) that will enable the CICO to meet all of SCDHHS's requirements as outlined in this Contract. The CICO's Systems shall be able to support current SCDHHS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following SCDHHS standards:
  - 2.15.3.1.1.1. The SCDHHS Unified Process Methodology User Guide;
  - 2.15.3.1.1.2. The User Experience and Style Guide Version 2.0;
  - 2.15.3.1.1.3. Information Technology Architecture Version 2.0; and
  - 2.15.3.1.1.4. Enterprise Web Accessibility Standards 2.0.
- 2.15.3.1.2. Ensure a secure, HIPAA-compliant exchange of Enrollee information between the CICO and SCDHHS and any other entity deemed appropriate by SCDHHS. Such files shall be transmitted to SCDHHS through secure FTP, HTS, or a similar secure data exchange as determined by SCDHHS;

- 2.15.3.1.3. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to quickly and easily locate all relevant information. If directed by SCDHHS, establish appropriate links on the CICO's website that direct users back to the SCDHHS website portal;
  - 2.15.3.1.4. The CICO shall cooperate with SCDHHS in its efforts to verify the accuracy of all CICO data submissions to SCDHHS; and
  - 2.15.3.1.5. Actively participate in any SCDHHS Systems Workgroup, as directed by SCDHHS. The Workgroup shall meet in the location and on a schedule determined by SCDHHS
- 2.15.3.2. Design Requirements
- 2.15.3.2.1. The CICO shall comply with SCDHHS requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.
  - 2.15.3.2.2. The CICO's Systems shall interface with SCDHHS Legacy MMIS system, SCDHHS' MMIS system, the SCDHHS Virtual Gateway, and other SCDHHS IT architecture.
  - 2.15.3.2.3. The CICO shall have adequate resources to support the MMIS interfaces. The CICO shall demonstrate the capability to successfully send and receive interface files. Interface files, which include, but are not limited to:
    - 2.15.3.2.3.1. Inbound Interfaces
    - 2.15.3.2.3.2. Daily Inbound Demographic Change File;
    - 2.15.3.2.3.3. HIPAA 834 History Request File;
    - 2.15.3.2.3.4. Inbound Co-pay Data File (daily); and
    - 2.15.3.2.3.5. Monthly CICO Provider and Pharmacy Directory.
    - 2.15.3.2.3.6. Outbound Interfaces

2.15.3.2.3.7. HIPAA 834 Outbound Daily File;

2.15.3.2.3.8. HIPAA 834 Outbound Full File;

2.15.3.2.3.9. HIPAA 834 History Response;

2.15.3.2.3.10. Fee-For-Service Wrap Services;

2.15.3.2.3.11. HIPAA 820; and

2.15.3.2.3.12. TPL Carrier Codes File.

2.15.3.2.4. The CICO shall conform to HIPAA compliant standards for data management and information exchange.

2.15.3.2.5. The CICO shall demonstrate controls to maintain information integrity.

2.15.3.2.6. The CICO shall maintain appropriate internal processes to determine the validity and completeness of data submitted to SCDHHS.

#### 2.15.4. Accepting and Processing Assessment Data

##### 2.15.4.1. System Access Management and Information Accessibility Requirements

2.15.4.1.1. The CICO shall make all Systems and system information available to authorized CMS, SCDHHS and other agency staff as determined by CMS or SCDHHS to evaluate the quality and effectiveness of the CICO's data and Systems.

2.15.4.1.2. The CICO is prohibited from sharing or publishing CMS or SCDHHS data and information without prior written consent from CMS or SCDHHS.

##### 2.15.4.2. System Availability and Performance Requirements

2.15.4.2.1. The CICO shall ensure that its Enrollee and Provider web portal functions and phone-based functions are available to Enrollees and Providers twenty-four (24) hours a day, seven (7) days a week.



- 2.15.4.2.2. The CICO shall draft an alternative plan that describes access to Enrollee and Provider information in the event of system failure. Such plan shall be contained in the CICO's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to SCDHHS upon request. In the event of system failure or unavailability, the CICO shall notify SCDHHS upon discovery and implement the COOP immediately.
- 2.15.4.2.3. The CICO shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

## 2.15.5. Encounter Reporting

### 2.15.5.1. Requirements

- 2.15.5.1.1. The CICO must meet any diagnosis and/or encounter reporting requirements that are in place for Medicare Advantage plans and Medicaid managed care organizations, as may be updated from time to time.
- 2.15.5.1.2. Furthermore, the CICO's Systems shall generate and transmit Encounter Data files according to additional specifications as may be provided by CMS or SCDHHS and updated from time to time.
- 2.15.5.1.3. CMS and SCDHHS will provide technical assistance to the CICO for developing the capacity to meet encounter reporting requirements.
- 2.15.5.1.4. The CICO shall:
  - 2.15.5.1.4.1. Collect and maintain one hundred percent (100%) Encounter Data for all Covered Services provided to Enrollees, including from any subcapitated sources. Such data must be able to be linked to SCDHHS eligibility data;
  - 2.15.5.1.4.2. Participate in site visits and other reviews and assessments by CMS and SCDHHS, or its designee, for the purpose of evaluating the CICO's collection and maintenance of Encounter Data;

- 2.15.5.1.4.3. Upon request by CMS, SCDHHS, or their designee, provide medical records of Enrollees and a report from administrative databases of the Encounters of such Enrollees in order to conduct validation assessments. Such validation assessments may be conducted annually;
- 2.15.5.1.4.4. Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by CMS, SCDHHS, or their designee, in consultation with the CICO. Such Encounter Data shall include elements and level of detail determined necessary by CMS and SCDHHS. As directed by CMS and SCDHHS, such Encounter Data shall also include the National Provider Identifier (NPI) of the ordering and referring physicians and professionals and any National Drug Code (NDC);
- 2.15.5.1.4.5. Submit complete, timely, reasonable and accurate Encounter Data to CMS no less than monthly and in the form and manner specified by SCDHHS and CMS. CMS will forward Encounter Data directly to SCDHHS;
- 2.15.5.1.4.6. Submit Encounter Data that meets minimum standards for completeness and accuracy as defined by CMS and SCDHHS. The CICO must also correct and resubmit denied encounters as necessary;
- 2.15.5.1.4.7. Report as a voided claim in the monthly Encounter Data submission any claims that the CICO pays, and then later determines should not have paid.
- 2.15.5.1.4.8. If CMS, SCDHHS, or the CICO, determines at any time that the CICO's Encounter Data is not complete and accurate, the CICO shall:
  - 2.15.5.1.4.8.1. Notify CMS and SCDHHS, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

- 2.15.5.1.4.8.2. Submit for CMS and SCDHHS approval, within a timeframe established by CMS and SCDHHS, which shall in no event exceed thirty (30) days from the day the CICO identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;
- 2.15.5.1.4.8.3. Implement the CMS and SCDHHS-approved corrective action plan within a time frame approved by CMS and SCDHHS, which shall in no event exceed thirty (30) days from the date that the CICO submits the corrective action plan to CMS and SCDHHS for approval; and
- 2.15.5.1.4.8.4. Participate in a validation study to be performed by CMS, SCDHHS, and/or their designee, following the end of a twelve (12) month period after the implementation of the corrective action plan to assess whether the Encounter Data is complete and accurate. The CICO may be financially liable for such validation study.

### **Section 3. CMS and SCDHHS Responsibilities**

#### **3.1. Contract Management**

##### **3.1.1. Administration**

3.1.1.1. CMS and SCDHHS will designate a CMT that will include at least one representative from CMS and at least one contract manager from SCDHHS authorized and empowered to represent CMS and SCDHHS about all aspects of the Contract. Generally, the CMS part of the team will include the State Lead from the Medicare Medicaid Coordination Office (MMCO), Regional Office lead from the Consortium for Medicaid and Children's Health Operations (CMCHO), and an account manager from the Consortium for Health Plan Operations (CMHPO). The CMS representatives and SCDHHS representatives will act as liaisons between the CICO and CMS and SCDHHS for the duration of the Contract. The CMT will:

- 3.1.1.1.1. Monitor compliance with the terms of the Contract including issuance of joint notices of non-compliance/enforcement.
- 3.1.1.1.2. Coordinate periodic audits and surveys of the CICO;
- 3.1.1.1.3. Receive and respond to complaints;
- 3.1.1.1.4. Conduct regular meetings with the CICO;
- 3.1.1.1.5. Coordinate requests for assistance from the CICO and assign CMS and SCDHHS staff with appropriate expertise to provide technical assistance to the CICO;
- 3.1.1.1.6. Make best efforts to resolve any issues applicable to the Contract identified by the CICO, CMS, or SCDHHS;
- 3.1.1.1.7. Inform the CICO of any discretionary action by CMS or SCDHHS under the provisions of the Contract;
- 3.1.1.1.8. Coordinate review of marketing materials and procedures; and
- 3.1.1.1.9. Coordinate review of Grievance and Appeals data, procedures.

3.1.1.2. CMS and SCDHHS will review, approve, and monitor the CICO's outreach and orientation materials and procedures;

- 3.1.1.3. CMS and SCDHHS will review, approve, and monitor the CICO's Grievance and Appeals procedures;
- 3.1.1.4. CMS and SCDHHS may apply one or more of the sanctions provided in Section 5.3.14, including termination of the Contract in accordance with Section 5.5, if CMS and the SCDHHS determine that the CICO is in violation of any of the terms of the Contract stated herein;
- 3.1.1.5. CMS and SCDHHS will conduct site visits as determined necessary by CMS and SCDHHS to verify the accuracy of reported data;
- 3.1.1.6. CMS and SCDHHS will coordinate the CICO's external quality reviews conducted by the EQRO; and,
- 3.1.1.7. CMS and SCDHHS will send transition reports to the CICO in an electronic format

### 3.1.2. Performance Evaluation

- 3.1.2.1. CMS and SCDHHS will, at their discretion:
  - 3.1.2.1.1. Evaluate, through inspection or other means, the CICO's compliance with the terms of this Contract, including, but not limited to, the reporting requirements in Sections 2.15 and 2.15.5, the quality, appropriateness, and timeliness of services performed by the CICO and its Provider Network. CMS and SCDHHS will provide the CICO with the written results of these evaluations;
  - 3.1.2.1.2. Conduct periodic audits of the CICO, including, but not limited to, an annual independent external review and an annual site visit;
  - 3.1.2.1.3. Conduct annual Enrollee surveys and provide the CICO with written results of such surveys; and
  - 3.1.2.1.4. Meet with the CICO at least semi-annually to assess the CICO's performance.

## 3.2. Enrollment and Disenrollment Systems

### 3.2.1. CMS and SCDHHS

- 3.2.1.1. Will maintain systems to provide Enrollment and disenrollment, information to the CICO; and continuous verification of eligibility status.

### 3.2.2. SCDHHS Enrollment Vendor

3.2.2.1. SCDHHS or its designee shall assign a staff person(s) who shall have responsibility to:

3.2.2.1.1. Develop generic materials to assist Eligible Enrollees in choosing whether to enroll in the Demonstration. Said materials shall present the CICO's Demonstration Plan in an unbiased manner to Enrollees eligible to enroll in the CICO. SCDHHS may collaborate with the CICO in developing CICO-specific materials;

3.2.2.1.2. Present each CICO in an unbiased manner to Eligible Enrollees or those seeking to transfer from one CICO to another. Such presentation(s) shall ensure that Enrollees are informed prior to enrollment of the following:

3.2.2.1.2.1. The rights and responsibilities of participation in the Demonstration;

3.2.2.1.2.2. The nature of the CICO's care delivery system, including, but not limited to the Provider Network; and the Comprehensive Assessment, and the MT;

3.2.2.1.2.3. Orientation and other Enrollee services made available by the CICO;

3.2.2.1.3. Enroll, disenroll, and process transfer requests of Enrollees in the CICO's CICO, including completion of SCDHHS' Enrollment and disenrollment forms;

3.2.2.1.4. Ensure that Enrollees are informed at the time of Enrollment or transfer of their right to terminate their Enrollment voluntarily at any time, unless otherwise provided by federal law or waiver;

3.2.2.1.5. Be knowledgeable about the CICO's policies, services, and procedures; and

3.2.2.1.6. At its discretion, develop and implement processes and standards to measure and improve the performance of the SCDHHS Enrollment Vendor staff. SCDHHS shall monitor the performance of the SCDHHS Enrollment Vendor.



## Section 4. Payment and Financial Provisions

### 4.1. General Financial Provisions

#### 4.1.1. Capitation Payments

- 4.1.1.1. CMS and SCDHHS will each contribute to the total Capitation Payment paid to the CICO. CMS and SCDHHS will each make monthly payments for each Enrollee to the CICO for their portion of the capitated rate, in accordance with the rates of payment and payment provisions set forth herein and subject to all applicable federal and state laws, regulations, rules, billing instructions, and bulletins, as amended.
- 4.1.1.2. The CICO will receive three (3) monthly payments for each Enrollee: one amount from CMS reflecting coverage of Medicare Parts A/B services (Medicare Parts A/B Component), one amount from CMS reflecting coverage Medicare Part D services (Medicare Part D Component), and a third amount from SCDHHS reflecting coverage of Medicaid services (Medicaid Component).
- 4.1.1.3. The Medicare Parts A/B payment will be risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.2.4.1. The Medicare Part D payment will be risk adjusted using the Part D RxHCC Model. The Medicaid Component will utilize the rate cell methodology described in Section 4.2.
- 4.1.1.4. CMS and SCDHHS will provide the CICO with a rate report on an annual basis for the upcoming calendar year.

#### 4.1.2. Demonstration Year Dates

- 4.1.2.1. Capitation Rate updates will take place on January 1<sup>st</sup> of each calendar year or more frequently, as described in this section; however, savings percentages and quality withhold percentages (see Sections 4.2.3 and 4.4.4) will be applied based on Demonstration Years, as follows:
  - 4.1.2.1.1. Demonstration Year 1: January 1, 2015-December 31, 2015
  - 4.1.2.1.2. Demonstration Year 2: January 1, 2016-December 31, 2016
  - 4.1.2.1.3. Demonstration Year 3: January 1, 2017-December 31, 2017



## 4.2. Capitated Rate Structure

### 4.2.1. Medicaid Component of the Capitation Payment

4.2.1.1. SCDHHS shall pay the CICO a monthly capitation amount (the Medicaid Component) based on the rate cell of the Enrollee, a sum equal to the product of the approved Capitation Rate and the number of Enrollees enrolled in that category as of the first day of that month.

4.2.1.1.1. Except as provided in Section 4.5.1, an Enrollee's rate cell will be determined by his or her residential status as of the first day of the month and as outlined in Exhibit 1 Medicaid Rate Cell Categories. SCDHHS will use its eligibility system to determine an Enrollee's rate cell. When there are delays in changes to an Enrollee's residential status in SCDHHS eligibility system, SCDHHS will adjust past Capitation Payments as needed.

4.2.1.2. The baseline spending data for Medicaid services used for calculating the Capitation Rates is the most recent two-year historical fee-for-service data from the total population that would have been eligible for Enrollment in the Demonstration during the historical baseline period. Completion factors are calculated and applied to the baseline data, in order to include expenditures for services that were incurred but not reported in the available data. The data are then adjusted for known policy and program changes that will be in effect during the contract period. The completed and adjusted data are trended forward to the midpoint of the contract period and used to develop Capitation Rates. All steps in this process are subject to CMS review.

4.2.1.3. The Capitation Payments are based on the rate cell structure and are generated by SCDHHS at the rates established in this Contract. Any and all costs incurred by the CICO in excess of the Capitation Payment will be borne in full by the CICO.

## Exhibit 1 Medicaid Rate Cell Categories

Rate Cell	Description
NF1: Nursing Facility-based Care	Includes individuals identified as having a nursing facility stay of more than 3 months and meeting Medicare skilled nursing criteria or Medicaid Nursing facility Level of Care
H1: Home and Community Based Services	<p>Includes individuals who do not meet NF1 criteria, and for whom a level of care determination indicates that the individual meets the level of care requirements for nursing facility placement and/or applicable HCBS waiver. These requirements include:</p> <ul style="list-style-type: none"> <li>• For the Community Choices waiver, meet the following level of care requirements: <ul style="list-style-type: none"> <li>○ Skilled Level of Care – need at least one skilled service and have a least one functional deficit, as defined in the waiver, or;</li> <li>○ Intermediate Level of Care – need at least one intermediate service and have at least one functional deficit or have at least two functional deficits, as defined by the waiver.</li> </ul> </li> <li>• For the HIV/AIDS waiver, be determined at-risk for hospitalization as defined in 42 CFR §440.10.</li> <li>• For the Mechanical Ventilation waiver, meet nursing home level of care and are dependent of a life-sustaining ventilator for six (6) or more hours per day, as defined by the waiver.</li> </ul>
H2: Home and Community Based Services Plus	Includes individuals moving from the NF1 rate cell to a qualifying HCBS waiver for the first 3 months of transition.
C1: Community Tier – Community	Includes individuals who do not meet NF1, H1, or H2 criteria.

### 4.2.2. Medicare Component of the Capitation Rate

4.2.2.1. Medicare will pay the CICO a monthly capitation amount for the Medicare Parts A/B services (the Medicare A/B Component), risk adjusted using the Medicare Advantage CMS-HCC Model and the CMS-HCC ESRD Model, except as specified in Section 4.2.4. Medicare will also pay the CICO a monthly capitation amount for Medicare Part D services, risk adjusted using the Part D RxHCC Model (the Medicare Part D Component).

4.2.2.2. Medicare A/B Component

4.2.2.2.1. The Medicare baseline spending for Parts A/B services are a blend of the Medicare Advantage projected payment rates and the Medicare FFS standardized county rates for each year, weighted by the proportion of the target population that will be transitioning from each program into the Demonstration. The Medicare Advantage baseline spending will include costs that would have occurred absent the Demonstration, such as quality bonus payments for applicable Medicare Advantage plans. The FFS county rates will generally reflect amounts published with the April Medicare Advantage Final Rate Announcement, adjusted to fully incorporate more current hospital wage index and physician geographic practice cost index information; in this Demonstration, this adjustment will be fully applied to the FFS county rates in 2014, but the adjustment will otherwise use the same methodologies and timelines used to make the analogous adjustments in Medicare Advantage. CMS may also further adjust the Medicare FFS standardized county rates as necessary to calculate accurate payment rates for the Demonstration. To the extent that the published FFS county rates do not conform with current law in effect for Medicare during an applicable payment month, and to the extent that such nonconformance would have a significant fiscal impact on the Demonstration, CMS will update the baseline (and therefore the corresponding payment rate) to calculate and apply an accurate payment rate for such month. Such update may take place retroactively, as needed.

4.2.2.2.2. Separate baselines will exist for Enrollees meeting the Medicare ESRD criteria. For Enrollees with ESRD in the dialysis or transplant status phases, the Medicare Parts A/B baseline will be the ESRD dialysis state rate. For Enrollees in the functioning graft status phase, the Medicare Parts A/B baseline will be the Medicare Advantage 3-star county rate (benchmark) for the applicable county.

- 4.2.2.2.3. Both baseline spending and payment rates under the Demonstration for Medicare Parts A/B services will be calculated as per member per month (PMPM) standardized amounts for each county participating in the Demonstration for each year. Enrollee risk scores will be applied to the standardized rates at the time of payment.
- 4.2.2.2.4. The Medicare A/B Component will be updated annually consistent with annual FFS estimates and Medicare Advantage rates released each year with the annual rate announcement.

#### 4.2.2.3. Medicare Part D

- 4.2.2.3.1. The Medicare Part D baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount (NAMBA) for the calendar year. CMS will estimate an average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts; these payments will be reconciled after the end of each payment year in the same manner as for all Part D sponsors. The CY 2014 Part D NAMBA is \$75.88.
- 4.2.2.3.2. The monthly Medicare Part D Component for an Enrollee can be calculated by multiplying the Part D NAMBA by the RxHCC risk score assigned to the individual, and then adding to this estimated average monthly prospective payment amount for the low income cost-sharing subsidy and federal reinsurance amounts.

#### 4.2.3. Aggregate Savings Percentages

- 4.2.3.1. Aggregate savings percentages will be applied equally, as follows, to the baseline spending amounts for the Medicare Parts A/B Component and the Medicaid Component of the capitated rate, provided that such savings percentages may be adjusted in accordance with Section 4.2.3.2.
  - 4.2.3.1.1. Demonstration Year 1: 1%
  - 4.2.3.1.2. Demonstration Year 2: 2%
  - 4.2.3.1.3. Demonstration Year 3: 4%

- 4.2.3.2. Rate updates will take place on January 1st of each calendar year, however savings percentages will be calculated and applied based on Demonstration Years.
- 4.2.3.3. Savings percentages will not be applied to the Part D component of the rate. CMS will monitor Part D costs closely on an ongoing basis. Any material change in Part D costs relative to the baseline may be factored into future year savings percentages.
- 4.2.4. Risk Adjustment Methodology
  - 4.2.4.1. Medicare Parts A/B: The Medicare Parts A/B Component will be risk adjusted based on the risk profile of each Enrollee. Except as specified below, the existing Medicare Advantage CMS-HCC and CMS-HCC ESRD risk adjustment methodology will be used for the Demonstration.
    - 4.2.4.1.1. In calendar year 2014, CMS will calculate and apply a coding intensity adjustment reflective of all Demonstration Enrollees. This will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in 2014 with Medicare Advantage experience in 2013, prior to the Demonstration.
    - 4.2.4.1.2. In calendar year 2015, CMS will apply an appropriate coding intensity adjustment reflective of all Demonstration Enrollees; this will apply the prevailing Medicare Advantage coding intensity adjustment proportional to the anticipated proportion of Demonstration Enrollees in CY 2015 with prior Medicare Advantage experience and/or Demonstration experience based on the Demonstration's Enrollment phase-in as of September 30, 2014.
    - 4.2.4.1.3. After calendar year 2015, CMS will apply the prevailing Medicare Advantage coding intensity adjustment to all Demonstration Enrollees.
    - 4.2.4.1.4. The coding intensity adjustment factor will not be applied during the Demonstration to risk scores for Enrollees with an ESRD status of dialysis or transplant, consistent with Medicare Advantage policy.
  - 4.2.4.2. Medicare Part D: The Medicare Part D NAMBA will be risk adjusted in accordance with existing Part D RxHCC methodology. The

estimated average monthly prospective payment amount for the low income cost-sharing subsidy and Federal reinsurance amounts will not be risk adjusted.

- 4.2.4.3. Medicaid: The Medicaid component will employ rating categories described in Section 4.2.1.

#### 4.3. Medical Loss Ratio (MLR)

##### 4.3.1. Medical loss ratio Guarantee

- 4.3.1.1. The CICO has a target medical loss ratio of eighty-five percent (85%).
- 4.3.1.2. If the medical loss ratio calculated as set forth below is less than the target medical loss ratio, the CICO shall refund to SCDHHS and CMS an amount equal to the difference between the calculated MLR and the target MLR (expressed as a percentage) multiplied by the coverage year revenue. SCDHHS and CMS shall calculate a MLR for Enrollees under this Contract for each coverage year, beginning with calendar year 2015, and shall provide to the CICO the amount to be refunded, if any, to SCDHHS and CMS respectively. Any refunded amounts will be distributed back to the Medicaid and Medicare programs, with the amount to each payor based on the proportion between the Medicare and Medicaid Components. At the option of CMS and SCDHHS, separately, any amount to be refunded may be recovered either by requiring the CICO to make a payment or by an offset to future Capitation Payment. The MLR calculation shall be determined as set forth below; however, SCDHHS and CMS may adopt NAIC reporting standards and protocols after giving written notice to the CICO.
- 4.3.1.3. MLR will be based on the 42 C.F.R. §§ 422.2400 et seq and 423.2400 et seq except that the numerator in the MLR calculation will include:
  - 4.3.1.3.1. All Covered Services required in the Demonstration under Section 2.4 and Appendix A;
  - 4.3.1.3.2. Any services purchased in lieu of more costly Covered Services and consistent with the objectives of the Demonstration; and
  - 4.3.1.3.3. Care Coordination Expense. That portion of the personnel costs for Care Coordinators whose primary duty is direct Enrollee contact that is attributable to this Contract shall be included as a benefit expense. The portion of the personnel costs for CICO's medical director that is attributable to this Contract shall be included as a benefit expense.

- 4.3.1.4. The revenue used in the MLR calculation will consist of the Capitation payments, as adjusted pursuant to Section 4.2.4, due from SCDHHS and CMS for services provided during the coverage year. Revenue will include amounts withheld pursuant to Section 4.4.4, regardless of whether the CICO actually receives the amount in Section 4.4.4.
- 4.3.1.5. Data Submission. The CICO shall submit to SCDHHS and CMS, in the form and manner prescribed by SCDHHS and CMS, the necessary data to calculate and verify the MLR within seven (7) months after the end of the coverage year.
- 4.3.1.6. Medical Loss Ratio Calculation. Within ninety (90) days following the six (6) month claims run-out period following the coverage year, SCDHHS and CMS shall calculate the MLR by dividing the benefit expense by the revenue. The MLR shall be expressed as a percentage rounded to the second decimal point. The CICO shall have sixty (60) days to review the MLR calculation. Each party shall have the right to review all data and methodologies used to calculate the MLR.
- 4.3.1.7. Coverage Year. The coverage year shall be the calendar year. The MLR calculation shall be prepared using all data available from the coverage year, including IBNP and six (6) months of run-out for benefit expense (excluding sub-capitation paid during the run-out months).

#### 4.4. Payment Terms

##### 4.4.1. Timing of Capitation Payments

- 4.4.1.1. CMS and SCDHHS will each make monthly Capitation Payments to the CICO. If an individual is enrolled with the CICO on the first day of a month, the CICO has the responsibility of providing Covered Services to that Enrollee for that month, even if the Enrollee moves to another locality. If the Enrollee moves to a locality outside of the CICO's Service Area, the Enrollee will be disenrolled from the CICO at the end of the month of change. Any and all costs incurred by the CICO in excess of the Capitation Payment will be borne in full by the CICO. The CICO shall accept SCDHHS's electronic transfer of funds to receive Capitation Payments.
- 4.4.1.2. The Medicare Parts A/B Component will be the product of the Enrollee's CMS-HCC risk score multiplied by the relevant standard county payment rate (or the ESRD dialysis state rate by the HCC ESRD risk score, as applicable). The Medicare Part D Component will be the product of the Enrollee's RxHCC risk score multiplied by the Part D NAMBA, with the addition of the estimated average

monthly prospective payment for the low-income cost-sharing subsidy and federal reinsurance amounts.

4.4.1.3. The Medicaid component for each rate cell will be product of the number of Enrollees in each category multiplied by the payment rate for that rate cell.

4.4.1.4. Enrollee contributions will not be deducted during the initial three (3) months when an Enrollee enters into a nursing facility.

4.4.1.5. Enrollments

4.4.1.5.1. CMS will make monthly PMPM Capitation Payment to the CICO. The PMPM Capitation Payment for a particular month will reflect payment for the Enrollees with effective Enrollment into the CICO's Demonstration plan as of the first day of that month as outlined in 2.3.2.

4.4.1.5.2. Capitation rates are calculated net of an estimated average patient pay amount. The net amount is calculated by applying estimated reimbursement rate changes to the gross facility rate and subtracting trended average pay amounts.

4.4.1.5.3. SCDHHS will make monthly PMPM Capitation Payments to the CICO prospectively for the next month's Enrollment (e.g., payment for June Enrollment will occur in May, July payment will be made in June). The PMPM Capitation Payment for a particular month will reflect payment for the Enrollees with effective Enrollment into the CICO's Demonstration plan as of the first day of the previous month.

4.4.1.6. Disenrollments

4.4.1.6.1. The final PMPM Capitation Payment made by CMS and SCDHHS to the CICO for each Enrollee will be for the month: a) in which the disenrollment was submitted, b) the Enrollee loses eligibility, or c) the Enrollee dies (see Section 2.3.5).

4.4.2. Enrollee Contribution to Care Amounts

4.4.2.1. Patient Liability is the payment amount required for individuals who are residing in nursing facilities. This amount is calculated using an individual's monthly recurring income minus a standard personal



needs allowance. Patient Liability is required to be calculated for every Enrollee receiving nursing facility services, although not every Eligible Beneficiary will be required to pay each month.

4.4.2.2. SCDHHS will provide information to the CICO that identifies Enrollees who are required to pay a Patient Liability amount and the amount of the obligation as part of the monthly transition report. SCDHHS Capitation Payments to CICOs for Enrollees who are required to pay a Patient Liability amount will be net of the actual monthly Patient Liability amount.

4.4.2.3. It is the responsibility of the nursing facility Provider(s) to collect the Patient Liability amount from Enrollees, and the CICO may reduce reimbursements to nursing facility Providers equal to the Patient Liability amount each month. Patient Liability amounts are to be collected at the beginning of the first full calendar month either upon completion of a traditional Medicare skilled/rehab stay or upon admission as a traditional Medicaid custodial resident.

#### 4.4.3. Modifications to Capitation Rates

4.4.3.1. CMS and SCDHHS may propose modifications, additions, or deletions to the rate cell structure over the course of the Demonstration. Any modifications to the rate cell structure will be subject to agreement by the other governmental party. CMS and SCDHHS will confer with the CICO on any such changes in advance as appropriate and possible. CMS and SCDHHS will inform the CICO of any decisions regarding changes in rate cell structures in writing, and the CICO shall accept such changes as payment in full as described in Section 4.7. Any mid-year rate changes would be articulated in a rate report.

4.4.3.2. Rates will be updated using a similar process for each calendar year. Subject to Section 4.4.3.3 below, changes to the Medicare and Medicaid baselines (and therefore to the corresponding payment rate) outside of the annual Medicare Advantage rate announcement and annual Medicaid rate update will be made only if and when CMS and SCDHHS jointly determine the change is necessary to calculate accurate payment rates for the Demonstration. Such changes may be based on the following factors: shifts in Enrollment assumptions; major changes or discrepancies in federal law and/or state policy used in the development of baseline estimates; and changes to coding intensity.

4.4.3.3. For changes solely affecting the Medicare program baseline. CMS will update baselines by amounts identified by the independent CMS

Office of the Actuary necessary to best effectuate accurate payment rates for each month.

- 4.4.3.4. Subject to Section 4.4.3.3 above, if other statutory changes enacted after the annual baseline determination and rate development process are jointly determined by CMS and the SCDHHS to have a material change in baseline estimates for any given payment year, baseline estimates and corresponding standardized payment rates shall be updated outside of the annual rate development process.
- 4.4.3.5. CMS and/or SCDHHS will make changes to baseline estimates within thirty (30) days of identification of the need for such changes, and changes will be applied, if necessary on a retrospective basis, to effectuate accurate payment rates for each month.
- 4.4.3.6. Changes to the savings percentages will be made if and when CMS and SCDHHS jointly determine that changes in Part D spending have resulted in materially higher or lower savings that need to be recouped through higher or lower savings percentages applied to the Medicare A/B baselines.
- 4.4.3.7. Any material changes in the Medicaid State Plan and 1915(c) waivers, including pertaining to Covered Services, payment schedules and related methodologies, shall be reflected in corresponding capitation payment adjustments. The CICO will not be required to implement such changes without advance notice and corresponding adjustment in the Capitation Payment. In addition, to the extent other Medicaid costs are incurred absent the Demonstration, such costs shall be reflected in corresponding Capitation Payment adjustments.

#### 4.4.4. Quality Withhold Policy

- 4.4.4.1. Under the Demonstration, both CMS and SCDHHS will withhold a percentage of their respective components of the Capitation Rate, with the exception of Part D component amounts. The withheld amounts will be repaid subject to the CICO's performance consistent with established quality thresholds.
- 4.4.4.2. CMS and SCDHHS will evaluate the CICO's performance according to the specified metrics required in order to earn back the quality withhold for a given year.
- 4.4.4.3. Whether or not the CICO has met the quality requirements in a given year will be made public.
- 4.4.4.4. Additional details regarding the quality withholds, including more detailed specifications, required thresholds and other information

regarding the methodology will be made available in future technical guidance.

4.4.4.5. Determination of whether the CICO has met required quality withhold requirements will be based solely on those measures that can appropriately be calculated based on actual enrollment volume during the demonstration year.

4.4.4.6. Withhold Measures in Demonstration Year 1

4.4.4.6.1. Exhibit 2 below identifies the withhold measures for Demonstration Year 1. Together, these will be utilized as the basis for a one percent (1%) withhold. Additional details, including technical specifications, withhold methodology and required benchmarks, will be provided in subsequent guidance.

**Exhibit 2 Quality Withhold Measures for Demonstration Year 1**

Domain	Measure	Source	CMS Core Withhold Measure	South Carolina Withhold Measure
Encounter data	Encounter data submitted accurately and completely in compliance with contract requirements.	CMS/State defined process measure	X	X
Assessments	Percent of Enrollees with initial assessments completed within 90 days of enrollment.	CMS/State defined process measure	X	X
Enrollee governance board	Establishment of Enrollee advisory board or inclusion of beneficiaries on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Individualized Care Plan	Proportion of Enrollees at each risk level (high-, medium-, low-) with Individual Care Plan (ICP) developed within specified timeframes compared to total Enrollees at each risk level requiring ICPs.	CMS/State defined process measure		X
Hospital, Nursing Facility and Community Transition Planning	CICO has an established work plan and systems in place, utilizing Phoenix as appropriate) for ensuring smooth transition to and from hospitals, nursing facilities and the community.	CMS/State defined process measure		X
Adjudicated Claims including HCBS Case Management	Percent of adjudicated claims submitted to CICOs that were paid within the timely filing requirements.			X

4.4.4.7. Withhold Measures in Demonstration Years 2 and 3

4.4.4.7.1. The quality withhold will increase to two percent (2%) in Demonstration Year 2 and three percent (3%) in Demonstration Year 3.

4.4.4.7.2. Payment will be based on performance on the quality withhold measures listed in Exhibit 3 below.

**Exhibit 3 Quality Withhold Measures for Demonstration Years 2 and 3**

Domain	Measure	Source	CMS Core Withhold Measure	South Carolina Withhold Measure
Customer Service	<p>Percent of best possible score the CICO earned on how easy it is to get information and help when needed.</p> <p>In the last six months, how often did your health plan’s customer service give you the information or help you needed?</p> <p>In the last six months, how often did your health plan’s customer service treat you with courtesy and respect?</p> <p>In the last six months, how often were the forms for your health plan easy to fill out?</p>	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	<p>Percent of best possible score the CICO earned on how quickly members get appointments and care</p> <p>In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?</p> <p>In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?</p> <p>In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?</p>	AHRQ/CAHPS	X	X

Domain	Measure	Source	CMS Core Withhold Measure	South Carolina Withhold Measure
Plan all-cause hospital readmissions	Percent of Enrollees discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	X
Annual flu vaccine	Percent of plan Enrollees who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS	X	
Follow-up after hospitalization for mental illness	Percentage of discharges for Enrollees 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.	NCQA/HEDIS	X	X
Screening for clinical depression and follow-up care	Percentage of patients age 21 years and older screened for clinical depression using a standard tool and follow-up plan documented.	CMS	X	
Reducing the risk of falling	Percent of Enrollees with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HOS	X	
Controlling blood pressure	Percentage of Enrollees 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	
Part D medication adherence for oral diabetes medications	Percent of plan Enrollees with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS	X	

Domain	Measure	Source	CMS Core Withhold Measure	South Carolina Withhold Measure
Management of Hospital, Nursing Facility and Community Transitions	<p>Percentage of enrollees who transitioned to and from hospitals, nursing facilities and the community.</p> <p>Proportion of those who transitioned to and from hospitals, nursing facilities and the community who returned to an (1) institutional setting or (2) community.</p> <p>Percentage of Care transitions recorded and transmitted to CICO Care Coordinator (via Phoenix)</p>	CMS/State defined process measure		X
Adjudicated Claims including HCBS Case Management	Percent of adjudicated claims submitted to CICO that were paid within the timely filing requirements.			X

#### 4.4.5. American Recovery and Reinvestment Act of 2009

4.4.5.1. All payments to the CICO are conditioned on compliance with all applicable provisions of the American Recovery and Reinvestment Act of 2009.

#### 4.4.6. Suspension of Payments

4.4.6.1. SCDHHS may suspend payments to the CICO in accordance with 42 C.F.R. § 455.23, *et seq.* and the [SCDHHS Managed Care Policies and Procedures Guide \(https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp\)](https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp) as determined necessary or appropriate by SCDHHS.

#### 4.5. Transitions between Rating Categories and Risk Score Changes

##### 4.5.1. Rating Category Changes

4.5.1.1. The Medicaid Component of the Capitation Rates will be updated following a change in an Enrollee's status relative to the rate cells in Section 4.2.1. On a monthly basis, as part of Capitation Payment processing, the rating category of each Enrollee will be determined.

4.5.1.2. The Medicaid Component payment implications for Enrollee movement among rate cells are described below.

- 4.5.1.2.1. SCDHHS will pay the HCBS Waiver Plus rate for the first three (3) months following the month of an nursing facility discharge for an Enrollee who had been in a nursing facility for at least ninety (90) days and moves to a HCBS Waiver.
- 4.5.1.2.2. SCDHHS will pay the HCBS Waiver Plus rate for the first three (3) months that an Enrollee, first eligible for nursing facility services or HCBS Waiver services, is served in a HCBS Waiver without being admitted to a nursing facility.
- 4.5.1.3. For nursing facility admissions, for the first three (3) months an Enrollee is a Resident of a nursing facility following the month of admission to a nursing facility, the SCDHHS will pay the Capitation Rate being paid during the month of admission, and not the Capitation Rate for the nursing facility rate cell.
- 4.5.2. Medicare Risk Score Changes
  - 4.5.2.1. Medicare CMS-HCC, HCC-ESRD, and RxHCC risk scores will be updated consistent with prevailing Medicare Advantage regulations and processes.
- 4.6. Reconciliation
  - 4.6.1. General
    - 4.6.1.1. CMS and SCDHHS will implement a process to reconcile Enrollment and Capitation Payments for the CICO that will take into consideration the following circumstances:
      - 4.6.1.1.1. Transitions between rate cells;
      - 4.6.1.1.2. Retroactive changes in eligibility, rate cells, or Enrollee contribution amounts;
      - 4.6.1.1.3. Changes in CMS-HCC and RxHCC risk scores; and,
      - 4.6.1.1.4. Changes through new Enrollment, disenrollment, or death.
    - 4.6.1.2. The reconciliation may identify underpayments or overpayments to the CICO.
  - 4.6.2. Medicaid Capitation Reconciliation

- 4.6.2.1. Retroactive adjustments to Enrollment and payment shall be forwarded to the CICO within thirty (30) days upon receipt of updated/corrected information. The CICO shall cover retroactive adjustments to Enrollment without regard to timelines of the adjustment. The CICO shall assure correct payment to Providers as a result of Enrollment updates/corrections. SCDHHS shall assure correct payment to the CICO for any retroactive Enrollment adjustments. Adjustments shall be retroactive no more than eighteen (18) months, unless otherwise agreed to by the CICO and the SCDDHS. Payments to the CICO will be adjusted for retroactive disenrollment of Enrollees, changes to Enrollee information that affect the Capitation Rates (e.g., eligibility classification), monetary sanctions and penalties imposed in accordance with Section 5.3.14, rate changes in accordance with Section 4.5.1, or other miscellaneous adjustments provided for herein.
- 4.6.3. Medicare Capitation Reconciliation
  - 4.6.3.1. Medicare capitation reconciliation will comply with prevailing Medicare Advantage and Part D regulations and processes.
- 4.6.4. Audits/Monitoring
  - 4.6.4.1. CMS and SCDHHS will conduct periodic audits to validate rate cell assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by CMS and SCDHHS.
- 4.7. Payment in Full
  - 4.7.1. General
    - 4.7.1.1. The CICO must accept as payment in full for all Covered Services the Capitation Rate(s) and the terms and conditions of payment set forth herein, except as provided in Appendix A Section A.1.
    - 4.7.1.2. Notwithstanding any contractual provision or legal right to the contrary, the three parties to this Contract (CMS, SCDHHS and the CICO), for this Demonstration agree there shall be no redress against either of the other two parties, or their actuarial contractors, over the actuarial soundness of the Capitation Rates.
    - 4.7.1.3. By signing this contract, the CICO accepts that the Capitation Rate(s) offered is reasonable; that operating within this Capitation Rate(s) is the sole responsibility of the CICO; and that while data is made available by the Federal Government to the CICO, any entity participating in the Demonstration must rely on their own resource to project likely experience under the Demonstration.



## Section 5. Additional Terms and Conditions

### 5.1. Administration

#### 5.1.1. Notification of Administrative Changes

5.1.1.1. The CICO must notify CMS and SCDHHS through HPMS of all changes affecting the key functions for the delivery of care, the administration of its program, or its performance of Contract requirements. The CICO must notify CMS and SCDHHS in HPMS no later than thirty (30) calendar days prior to any significant change to the manner in which services are rendered to Enrollees, including, but not limited to, procurement or termination of a First Tier, Downstream and Related Entity pursuant to Appendix E. The CICO must notify CMS and SCDHHS in HPMS of all other changes no later than five (5) business days prior to the effective date of such change.

#### 5.1.2. Assignment

5.1.2.1. The CICO may not assign or transfer any right or interest in this Contract to any successor entity or other entity without the prior written consent of CMS and SCDHHS, which may be withheld for any reason or for no reason at all.

#### 5.1.3. Independent CICOs

5.1.3.1. The CICO, its employees, First Tier, Downstream and Related Entities, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of the federal government, SCDHHS, or its authorized agents.

5.1.3.2. The CICO must ensure it evaluates the prospective First Tier, Downstream and Related Entities' abilities to perform activities to be delegated.

#### 5.1.4. Subrogation

5.1.4.1. Subject to CMS and SCDHHS lien and third-party recovery rights, the CICO must:

5.1.4.1.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder;

5.1.4.1.2. Require that the Enrollee pay to the CICO all such amounts recovered by suit, settlement, or otherwise from any third person or his or her insurer to the extent of the benefits provided hereunder, up to the value of the benefits provided hereunder. The CICO may ask the Enrollee to:

5.1.4.1.2.1. Take such action, furnish such information and assistance, and execute such instruments as the CICO may require to facilitate enforcement of its rights hereunder, and take no action prejudicing the rights and interest of the CICO hereunder; and

5.1.4.1.2.2. Notify the CICO hereunder and authorize the CICO to make such investigations and take such action as the CICO may deem appropriate to protect its rights hereunder whether or not such notice is given.

#### 5.1.5. Prohibited Affiliations

5.1.5.1. In accordance with 42 USC §1396 u-2(d)(1), the CICO shall not knowingly have an employment, consulting, or other agreement for the provision of items and services that are significant and material to the CICO's obligations under this Contract with any person, or affiliate of such person, who is excluded, under federal law or regulation, from certain procurement and non-procurement activities. Further, no such person may have beneficial ownership of more than five (5) percent of the CICO's equity or be permitted to serve as a director, officer, or partner of the CICO.

#### 5.1.6. Disclosure Requirements

5.1.6.1. The CICO must disclose to CMS and SCDHHS information on ownership and control, business transactions, and persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B. The CICO must obtain federally required disclosures from all Network Providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R. § 1002.3, and as specified by SCDHHS, including, but not limited to, obtaining such information through Provider Enrollment forms and credentialing and recredentialing packages. The CICO must maintain such disclosed information in a manner which can be periodically searched by the CICO for exclusions and provided to SCDHHS in accordance with this Contract and relevant state and federal laws and regulations. In addition, the CICO must comply with all reporting and disclosure requirements of 42 U.S.C. §

1396b(m)(4)(A) if the CICO is not a federally qualified health maintenance organization under the Public Health Service Act.

5.1.7. Physician Identifier

5.1.7.1. The CICO must require each physician providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. § 1320d-2(b). The CICO must provide such unique identifier to CMS and SCDHHS for each of its PCPs in the format and time-frame established by CMS and SCDHHS in consultation with the CICO.

5.1.8. Timely Provider Payments

5.1.8.1. The CICO must make timely payments to its Providers. The CICO must include a prompt payment provision in its contracts with Providers and suppliers, the terms of which are developed and agreed to by both the CICO and the relevant Provider.

5.1.8.2. Cleans claims are those which can be processed without obtaining additional information from the physician or from a third party.

5.1.8.3. The CICO shall pay ninety percent (90%) of all clean claims from Providers within thirty (30) days of the date of receipt.

5.1.8.4. The CICO shall pay ninety-nine percent (99%) of all clean claims from Providers, within ninety (90) days of the date of receipt.

5.1.8.5. The date of receipt is the date as indicated by its date stamp on the claim.

5.1.8.6. The date of payment is the date of the check or other form of payment.

5.1.8.7. The CICO and its Providers may, by mutual agreement, establish an alternative payment schedule.

5.1.8.8. The SCDHHS may conduct audits of the CICO by using the date of service and date of payment to identify and audit the CICO to ensure the CICO is adhering to the requirement.

5.1.8.9. In conjunction with Provider LTSS workgroups, the CICO will develop uniform claims submission standards. Uniform standards include but are not limited to the utilization of a web-based portal for initial claims submission and to reduce claim denial.

5.1.8.9.1. The CICO shall develop and implement protocols, prior approved by SCDHHS, that specify the CICO's criteria for providing one-on-one assistance to a Provider and the type of assistance the CICO will provide. At a minimum, the CICO shall contact a Provider if, during the first year after implementation of the Demonstration, the CICO has or will deny ten percent (10%) or more of the total value of the Provider's claims for a rolling thirty (30) day period, and shall, in addition to issuing a remittance advice, contact the Provider to review each of the error(s)/reason(s) for denial and advise how the Provider can correct the error for resubmission (as applicable) and avoid the error/reason for denial in the future.

5.1.8.9.2. The CICO shall provide one-on-one assistance to LTSS Providers as needed to help Providers submit clean and accurate claims and minimize claim denial.

5.1.8.10. HCBS Providers, including self-directed attendant care Providers, must be paid weekly unless otherwise agreed upon within the individual Provider contracts. All complete claims submitted via Phoenix are transmitted to the CICO daily (except Mondays) for payment processing.

#### 5.1.9. Protection of Enrollee-Provider Communications

5.1.9.1. In accordance with 42 USC §1396 u-2(b)(3), the CICO shall not prohibit or otherwise restrict a Provider or clinical First Tier, Downstream or Related Entity from advising an Enrollee about the health status of the Enrollee or medical care or treatment options for the Enrollee's condition or disease; information the Enrollee needs in order to decide among all relevant treatment options; risk, benefits and consequences of treatment or non-treatment; and/or the Enrollee's rights to participate in decisions about his or her health care, including the right to refuse treatment and to express preferences about future treatment decisions, regardless of whether benefits for such care or treatment are provided under the Contract, if the Provider or clinical First Tier, Downstream or Related Entity is acting within the lawful scope of practice.

#### 5.1.10. Protecting Enrollee from Liability for Payment

5.1.10.1. The CICO must:

- 5.1.10.1.1. In accordance with 42 C.F.R. § 438.106, not hold an Enrollee liable for:
  - 5.1.10.1.1.1. Debts of the CICO, in the event of the CICO's insolvency;
  - 5.1.10.1.1.2. Covered services provided to the Enrollee in the event that the CICO fails to receive payment from CMS or SCDHHS for such services;
  - 5.1.10.1.1.3. Covered services provided to the Enrollee in the event that the CICO or SCDHHS fail to make payment to the individual or health care Provider that furnished the services under a contractual, referral, or other arrangement; or
  - 5.1.10.1.1.4. Payments to a clinical First Tier, Downstream and Related Entity in excess of the amount that would be owed by the Enrollee if the CICO had directly provided the services.
- 5.1.10.1.2. Not charge Enrollees coinsurance, co-payments, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as otherwise provided in Appendix A;
- 5.1.10.1.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any applicable charge;
- 5.1.10.1.4. Not deny any service provided under this Contract to an Enrollee who, prior to becoming eligible for the South Carolina Capitated Financial Alignment Demonstration, incurred a bill that has not been paid; and
- 5.1.10.1.5. Ensure Provider Network compliance with all Enrollee payment restrictions, including balance billing restrictions, and develop and implement a plan to identify and revoke or provide other specified remedies for any member of the CICO's Provider Network that does not comply with such provisions.

#### 5.1.11. Moral or Religious Objections

- 5.1.11.1. The CICO is not required to provide, reimburse for, or provide coverage of, a counseling or referral service that would otherwise be required if the CICO objects to the service on moral or religious

grounds. If the CICO elects not to provide, reimburse for, or provide coverage of, a counseling or referral service because of an objection on moral or religious grounds, it must furnish information about the services it does not cover as follows:

- 5.1.11.1.1. To SCDHHS;
- 5.1.11.1.2. With its application for a Contract;
- 5.1.11.1.3. Whenever it adopts the policy during the term of the contract; and
- 5.1.11.1.4. The information provided must be:
  - 5.1.11.1.4.1. Consistent with the provisions of 42 C.F.R. § 438.10,
  - 5.1.11.1.4.2. Provided to Eligible Beneficiaries before and during Enrollment; and
  - 5.1.11.1.4.3. Provided to Enrollees within ninety (90) days after adopting the policy with respect to any particular service.

## 5.1.12. Third Party Liability Comprehensive Health Coverage

### 5.1.12.1. General Requirements

- 5.1.12.1.1. Enrollees, determined by SCDHHS as having comprehensive health coverage other than Medicare or Medicaid, will be assigned to the fee-for-service program, effective the first day of the month following the month in which the coverage was verified. Enrollees will not be retroactively disenrolled due to comprehensive health coverage. Until disenrollment occurs, the CICO is responsible for coordinating all benefits covered under this contract.

- 5.1.12.1.2. Under Section 1902 (a)(25) of the Social Security Act (42 U.S.C. §1396 a (a)(25)), SCDHHS is required to take all reasonable measures to identify legally liable third parties and pursue verified resources. In cases in which the Enrollee was not identified for exclusion prior to Enrollment in the CICO, the CICO shall take responsibility for identifying and pursuing comprehensive health coverage. Any moneys recovered by third parties shall be retained by the CICO and identified monthly to SCDHHS and CMS. The CICO shall notify SCDHHS and CMS on a monthly basis of any Enrollees identified during that past month who were discovered to have comprehensive health coverage.
- 5.1.12.1.3. CICOs shall follow the guidelines for all other Third Party Liability cases as outlined in the Medicaid Managed Care Contract (<https://msp.scdhhs.gov/managedcare/site-page/mco-contract-pp>).

## 5.2. Confidentiality

### 5.2.1. Statutory Requirements

- 5.2.1.1. The CICO understands and agrees that CMS and SCDHHS may require specific written assurances and further agreements regarding the security and privacy of protected health information that are deemed necessary to implement and comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 C.F.R., Parts 160 and 164 and the Medicaid regulations at 42 C.F.R. § 431.300 et seq. The CICO further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under the SCDHHS Managed Care Contract. The CICO represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable state and federal laws. The CICO is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93-579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

### 5.2.2. Personal Data

5.2.2.1. The CICO must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to design, development, operation, or maintenance, of the laws and regulations relating to confidentiality.

### 5.2.3. Data Security

5.2.3.1. The CICO must take reasonable steps to ensure the physical security of personal data or other confidential information under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held data by ensuring limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names.

5.2.3.2. The CICO must put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the privacy and security of protected health information in accordance with 45 C.F.R. §164.530(c).

5.2.3.3. The CICO must meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. Part 164, Subpart C, the HIPAA Security Rule.

5.2.3.4. The CICO must follow the National Institute for Standards and Technology (NIST) Guidelines for the Risk Management Framework (RMF) to establish an information security program in accordance with the Federal Information Security Management Act (FISMA).

### 5.2.4. Return of Personal Data

5.2.4.1. The CICO must return any and all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of CMS or SCDHHS in whatever form it is maintained by the CICO.

5.2.4.2. Upon the termination or completion of this Contract, the CICO shall not use any such data or any material derived from the data for any purpose, and, where so instructed by CMS or SCDHHS will destroy such data or material.

### 5.2.5. Destruction of Personal Data



- 5.2.5.1. For any PHI received regarding an Eligible Beneficiary referred to the CICO by SCDHHS but who does not enroll in CICO's plan, the CICO must destroy the PHI in accordance with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitizations, and all applicable state and federal privacy and security laws including HIPAA and its related implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time.
- 5.2.5.2. The CICO shall also adhere to standards described in OMB Circular No. A-130, Appendix III-Security of Federal Automated Information Systems and NIST Federal Information Processing Standard 200 entitled "Minimum Security Requirements for Federal Information and Information Systems" while in possession of all PHI.

#### 5.2.6. Research Data

- 5.2.6.1. The CICO must seek and obtain prior written authorization from CMS and SCDHHS for the use of any data pertaining to this Contract for research or any other purposes not directly related to the CICO's performance under this Contract.

### 5.3. General Terms and Conditions

#### 5.3.1. Applicable Law

- 5.3.1.1. The term "applicable law," as used in this Contract, means, without limitation, all federal and state law, and the regulations, policies, procedures, and instructions of CMS and SCDHHS all as existing now or during the term of this Contract. All applicable law is hereby incorporated into this Contract by reference.

#### 5.3.2. Sovereign Immunity

- 5.3.2.1. Nothing in this Contract will be construed to be a waiver by the State of South Carolina or CMS of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

#### 5.3.3. Advance Directives

- 5.3.3.1. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life-sustaining treatment as a condition of receipt of services under the Medicare or Medicaid program.

#### 5.3.4. Loss of Licensure or Certification

5.3.4.1. If, at any time during the term of this Contract, the CICO or any of its First Tier, Downstream or Related Entities incurs loss of licensure at any of the CICO's facilities or loss of necessary Federal or State approvals, the CICO must report such loss to CMS and SCDHHS. Such loss may be grounds for termination of this Contract under the provisions of Section 5.5.

5.3.5. Indemnification

5.3.5.1. The CICO shall indemnify and hold harmless CMS, the federal government, the State of South Carolina, and their agencies, officers, employees, agents and volunteers from and against any and all liability, loss, damage, costs, or expenses which CMS and or SCDHHS may sustain, incur, or be required to pay, arising out of or in connection with any negligent action, inaction, or willful misconduct of the CICO, any person employed by the CICO, or any of its First Tier, Downstream, or Related Entities provided that:

5.3.5.1.1. The CICO is notified of any claims within a reasonable time from when CMS and SCDHHS become aware of the claim; and

5.3.5.1.2. The CICO is afforded an opportunity to participate in the defense of such claims.

5.3.6. Prohibition against Discrimination

5.3.6.1. In accordance with 42 U.S.C. §1396 u-2(b)(7), the CICO shall not discriminate with respect to participation, reimbursement, or indemnification of any provider in the CICO's Provider Network who is acting within the scope of the provider's license or certification under applicable federal or state law, solely on the basis of such license or certification. This section does not prohibit the CICO from including providers in its Provider Network to the extent necessary to meet the needs of the CICO's Enrollees, using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the CICO.

5.3.6.2. The CICO shall abide by all federal and state laws, regulations, and orders that prohibit discrimination because of race, color, religion, sex, national origin, ancestry, age, physical or mental disability, including, but not limited to, the Federal Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, the Federal Rehabilitation Act of 1973,

Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975.

- 5.3.6.3. The CICO further agrees to take affirmative action to ensure that no unlawful discrimination is committed in any manner including, but not limited to, the delivery of services under this Contract.
- 5.3.6.4. The CICO will not discriminate against Eligible Beneficiaries or Enrollees on the basis of health status or need for health services.
- 5.3.6.5. The CICO will provide each Provider or group of Providers whom it declines to include in its network written notice of the reason for its decision.
- 5.3.6.6. Nothing in Section 5.3.6.5 above may be construed to require the CICO to contract with Providers beyond the number necessary to meet the needs of its Enrollees; precludes the CICO from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or precludes the CICO from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Enrollees.
- 5.3.6.7. If a Complaint or claim against the CICO is presented to SCDHHS for handling discrimination complaints, the CICO must cooperate with in the investigation and disposition of such Complaint or claim.

#### 5.3.7. Anti-Boycott Covenant

- 5.3.7.1. During the time this Contract is in effect, neither the CICO nor any affiliated company, as hereafter defined, must participate in or cooperate with an International boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful. Without limiting such other rights as it may have, CMS and SCDHHS will be entitled to rescind this Contract in the event of noncompliance with this Section.
- 5.3.7.2. As used herein, an affiliated company is any business entity directly or indirectly owning at least 51% of the ownership interests of the CICO.

#### 5.3.8. Information Sharing

- 5.3.8.1. During the course of an Enrollee's enrollment or upon transfer or termination of enrollment, whether voluntary or involuntary, and subject to all applicable federal and state laws, the CICO must arrange for the transfer, at no cost to CMS, SCDHHS, or the Enrollee, of medical information regarding such Enrollee to any subsequent

provider of medical services to such Enrollee, as may be requested by the Enrollee or such provider or directed by CMS and SCDHHS the Enrollee, regulatory agencies of the State of South Carolina, or the United States Government. With respect to Enrollees who are in the custody of the state, the CICO must provide, upon reasonable request of the state agency with custody of the Enrollee, a copy of said Enrollee's medical records in a timely manner.

#### 5.3.9. Other Contracts

5.3.9.1. Nothing contained in this Contract must be construed to prevent the CICO from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder provided, however, that the CICO must provide CMS and SCDHHS with a complete list of such plans and services, upon request. CMS and SCDHHS will exercise discretion in disclosing information that the CICO may consider proprietary, except as required by law. Nothing in this Contract may be construed to prevent CMS or SCDHHS from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

#### 5.3.10. Counterparts

5.3.10.1. This Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

#### 5.3.11. Entire Contract

5.3.11.1. This Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations, and undertakings not set forth or incorporated herein. The terms of this Contract will prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring.

#### 5.3.12. No Third-Party Rights or Enforcement

5.3.12.1. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

#### 5.3.13. Corrective Action Plan

5.3.13.1. If, at any time, CMS and SCDHHS reasonably determines that the CICO is deficient in the performance of its obligations under the

Contract, CMS and SCDHHS may require the CICO to develop and submit a corrective action plan that is designed to correct such deficiency. CMS and SCDHHS will approve, disapprove, or require modifications to the corrective action plan based on their reasonable judgment as to whether the corrective action plan will correct the deficiency. The CICO must promptly and diligently implement the corrective action plan as approved by CMS and SCDHHS. Failure to implement the corrective action plan may subject the CICO to termination of the Contract by CMS and SCDHHS or other intermediate sanctions as described in Section.

#### 5.3.14. Intermediate Sanctions and Civil Monetary Penalties

- 5.3.14.1. In addition to termination under Section 5.5, CMS and SCDHHS may, impose any or all of the sanctions in Subsection 5.3.17 upon any of the events below; provided, however, that CMS and SCDHHS will only impose those sanctions they determine to be reasonable and appropriate for the specific violations identified.
- 5.3.14.2. Sanctions may be imposed in accordance with regulations that are current at the time of the sanction.
- 5.3.14.3. Sanctions may be imposed in accordance with this section if the CICO:
  - 5.3.14.3.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;
  - 5.3.14.3.2. Imposes charges on Enrollees in excess of any permitted under this Contract;
  - 5.3.14.3.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;
  - 5.3.14.3.4. Misrepresents or falsifies information provided to CMS, SCDHHS and its authorized representatives, Enrollees, prospective Enrollees, or its Provider Network;
  - 5.3.14.3.5. Fails to comply with requirements regarding physician incentive plans (see Section 2.7.6.7.3);

- 5.3.14.3.6. Fails to comply with federal or state statutory or regulatory requirements related to this Contract;
  - 5.3.14.3.7. Violates restrictions or other requirements regarding marketing;
  - 5.3.14.3.8. Fails to comply with quality management requirements consistent with Section 2.11.7.1;
  - 5.3.14.3.9. Fails to comply with any corrective action plan required by CMS and SCDHHS;
  - 5.3.14.3.10. Fails to comply with financial solvency requirements;
  - 5.3.14.3.11. Fails to comply with reporting requirements; or
  - 5.3.14.3.12. Fails to comply with any other requirements of this Contract.
- 5.3.14.4. Such sanctions may include but are not limited to:
- 5.3.14.4.1. Intermediate sanctions consistent with 42 C.F.R. § 438.702
  - 5.3.14.4.2. Financial penalties consistent with 42 C.F.R. § 438.704;
  - 5.3.14.4.3. The appointment of temporary management to oversee the operation of the CICO in those circumstances set forth in 42 U.S.C. §1396 u-2(e)(2)(B);
  - 5.3.14.4.4. Suspension of Enrollment (including assignment of Enrollees);
  - 5.3.14.4.5. Suspension of payment to the CICO;
  - 5.3.14.4.6. Disenrollment of Enrollees;
  - 5.3.14.4.7. Suspension of marketing; and
  - 5.3.14.4.8. Denial of payment as set forth in 42 C.F.R. § 438.730.
- 5.3.14.5. If CMS or SCDHHS have identified a deficiency in the performance of a First Tier, Downstream or Related Entity and the CICO has not successfully implemented an approved corrective action plan in accordance with Section 5.3.13, CMS and SCDHHS may:

- 5.3.14.5.1. Require the CICO to subcontract with a different First Tier, Downstream or Related Entity deemed satisfactory by CMS and SCDHHS; or
    - 5.3.14.5.2. Require the CICO to change the manner or method in which the CICO ensures the performance of such contractual responsibility.
  - 5.3.14.6. Before imposing any intermediate sanctions, SCDHHS and CMS must give the CICO timely written notice that explains the basis and nature of the sanction and other due process protections that SCDHHS and CMS elect to provide.
- 5.3.15. Additional Administrative Procedures
  - 5.3.15.1. CMS and SCDHHS may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The CICO must comply with all such program memoranda as may be issued from time to time.
- 5.3.16. Effect of Invalidity of Clauses
  - 5.3.16.1. If any clause or provision of this Contract is officially declared to be in conflict with any federal or state law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract.
- 5.3.17. Conflict of Interest
  - 5.3.17.1. Neither the CICO nor any First Tier, Downstream or Related Entity may, for the duration of the Contract, have any interest that will conflict, as determined by CMS and SCDHHS with the performance of services under the Contract, or that may be otherwise anticompetitive. Without limiting the generality of the foregoing, CMS and SCDHHS require that neither the CICO nor any First Tier, Downstream, or Related Entity has any financial, legal and contractual, or other business interest in any entity performing CICO enrollment functions for SCDHHS. The CICO further certifies that it will comply with Section 1932(d) of the Social Security Act.
- 5.3.18. Insurance for CICO's Employees
  - 5.3.18.1. The CICO must agree to maintain at the CICO's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and must provide CMS and SCDHHS with certification of same upon request. The CICO, and its

professional personnel providing services to Enrollees, must obtain and maintain appropriate professional liability insurance coverage. The CICO must, at the request of CMS or SCDHHS, provide certification of professional liability insurance coverage.

#### 5.3.19. Waiver

5.3.19.1. The CICO, CMS, or SCDHHS shall not be deemed to have waived any of its rights hereunder unless such waiver is in writing and signed by a duly authorized representative. No delay or omission on the part of the CICO, CMS, or SCDHHS in exercising any right shall operate as a waiver of such right or any other right. A waiver on any occasion shall not be construed as a bar to or waiver of any right or remedy on any future occasion. The acceptance or approval by CMS and SCDHHS of any materials including, but not limited to, those materials submitted in relation to this Contract, does not constitute waiver of any requirements of this Contract.

#### 5.3.20. Section Headings

5.3.20.1. The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

#### 5.3.21. Other State Terms and Conditions

5.3.21.1. The CICO is prohibited from collecting estate recoveries. The CICO shall notify SCDHHS and CMS on a monthly basis of any Enrollees identified during the past month who have died.

5.3.21.2. The CICO shall maintain , throughout the performance of its obligations under this Contract, a policy or policies of worker's compensation insurance with such limits as may be required by law, and a policy or policies of general liability insurance insuring against liability for injury to, and death of, persons and damage to, and destruction of, property arising out of or based upon any act or omission of the CICO or any of its First Tier, Downstream, or Related Entities or their respective officers, directors, employees or agents. Such general liability insurance shall have limits sufficient to cover any loss or potential loss resulting from this Contract.

5.3.21.3. It shall be the responsibility of the CICO to require any First Tier, Downstream, or Related Entity to secure the same insurance as prescribed herein for the CICO. In addition, the CICO shall indemnify and hold harmless SCDHHS from any liability arising out of the CICO's untimely failure in securing adequate insurance coverage as prescribed herein. All such coverages shall remain in full force and effect during the initial term of the Contract and any renewal thereof.



- 5.3.21.4. The CICO shall hold a certificate of authority and file all contracts of reinsurance, or a summary of the plan of self-insurance. All reinsurance agreements or summaries of plans of self-insurance shall be filed with the SCDOI as required in S.C. Code Ann. §38-33-30 (D), (Supp. 2000, as amended) and any modifications thereto must be filed and approved by the SCDOI. Reinsurance agreements shall remain in full force and effect for at least thirty (30) calendar days following written notice by registered mail of cancellation by either party to the Director of the SCDOI or designee. The CICO's reinsurance agreements shall remain in force throughout the Contract period, including any extension(s) or renewal(s).
- 5.3.21.5. CICO must require any First Tier, Downstream or Related Entity to provide proof of accreditation annually. If the First Tier, Downstream, or Related Entity changes or intends to change its accreditation body the First Tier, Downstream, or Related Entity must notify the CICO within five (5) business days after the new accreditation has been achieved.
- 5.3.21.6. The CICO shall obtain, pay for, and keep in force for the duration of the Contract Errors and Omissions insurance, in the amount of at least One Million Dollars (\$1,000,000.00), per occurrence.

#### 5.4. Record Retention, Inspection, and Audits

##### 5.4.1. General

- 5.4.1.1. The CICO must maintain books, records, documents, and other evidence of administrative, medical, and accounting procedures and practices for ten years from the end of the final Contract period or completion of audit, whichever is later.
- 5.4.1.2. The CICO must make the records maintained by the CICO and its Provider Network, as required by CMS and SCDHHS and other regulatory agencies, available to CMS and SCDHHS and its agents, designees or CICOs or any other authorized representatives of the State of South Carolina or the United States Government, or their designees or CICOs, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial or medical audits, inspections, and examinations, provided that such activities are conducted during the normal business hours of the CICO.
- 5.4.1.3. The CICO further agrees that the Secretary of the U.S. Department of Health and Human Services or his or her designee, the Governor or his or her designee, Comptroller General or his or her designee, and the State Auditor or his or her designee have the right at reasonable times

and upon reasonable notice to examine the books, records, and other compilations of data of the CICO and its First Tier, Downstream and Related Entities that pertain to: the ability of the CICO to bear the risk of potential financial losses; services performed; or determinations of amounts payable.

- 5.4.1.4. The CICO must make available, for the purposes of record maintenance requirements, its premises, physical facilities and equipment, records relating to its Enrollees, and any additional relevant information that CMS or SCDHHS may require, in a manner that meets CMS and SCDHHS' record maintenance requirements.
- 5.4.1.5. The CICO must comply with the right of the U.S. Department of Health and Human Services, the Comptroller General, and their designees to inspect, evaluate, and audit records through ten years from the final date of the Contract period or the completion of audit, whichever is later, in accordance with federal and state requirements.

## 5.5. Termination of Contract

### 5.5.1. General

- 5.5.1.1. In the event the CICO materially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or South Carolina Medicaid programs, CMS or SCDHHS may take any or all action under this Contract, law, or equity, including, but not limited to, immediate termination of this Contract. CMS or SCDHHS may terminate the contract in accordance with regulations that are current at the time of the termination.

### 5.5.2. Termination without Prior Notice

- 5.5.2.1. Without limiting the above, if CMS and SCDHHS determine that participation of the CICO in the Medicare or South Carolina Medicaid program or in the Demonstration, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the Medicare or South Carolina Medicaid program, CMS or SCDHHS, without prior notice, may immediately terminate this Contract, suspend the CICO from participation, withhold any future payments to the CICO, or take any or all other actions under this Contract, law, or equity. Such action may precede Enrollment of Eligible Beneficiaries into any CICO, and shall be taken upon a finding by CMS or SCDHHS that the CICO has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of Medicare-Medicaid services to Enrollees.

- 5.5.2.2. United States law will apply to resolve any claim of breach of this Contract.
- 5.5.3. Termination with Prior Notice
  - 5.5.3.1. CMS or SCDHHS may terminate this Contract without cause upon no less than one hundred and twenty (120) days prior written notice to the other party specifying the termination date, unless applicable law requires otherwise. Per Section 5.7, the CICO may choose to non-renew prior to the end of each term pursuant to 42 C.F.R. § 422.506(a) and may terminate the Contract by mutual consent of CMS and SCDHHS at any time pursuant to 42 C.F.R. § 422.508. In considering requests for termination under 42 C.F.R. § 422.508, CMS and SCDHHS consider, among other factors, financial performance and stability in granting consent for termination. Any written communications or oral scripts developed to implement the requirements of 42 C.F.R. § 422.506(a) must be submitted to and approved by CMS and SCDHHS prior to their use.
  - 5.5.3.2. Pursuant to 42 C.F.R. §§ 422.506(a)(4) and 422.508(c), CMS considers CICO termination of this Contract with prior notice as described in Section 5.5.3 and non-renewal of this Contract as described in Section 5.7 to be circumstances warranting special consideration, and will not prohibit the CICO from applying for new Medicare Advantage contracts or Service Area expansions for a period of two (2) years due to termination.
- 5.5.4. Termination pursuant to Social Security Act § 1115A(b)(3)(B).
- 5.5.5. Termination for Cause
  - 5.5.5.1. Any party may terminate this Agreement upon ninety (90) days' notice due to a material breach of a provision of this Contract unless CMS or SCDHHS determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the CICO or the CICO experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby CMS or SCDHHS may expedite the termination.
  - 5.5.5.2. Pre-termination Procedures: Before terminating a contract under 42 C.F.R. § 422.510 and § 438.708, the CICO may request a pre-termination hearing or develop and implement a corrective action plan. CMS or SCDHHS must:

- 5.5.5.2.1. Give the CICO written notice of its intent to terminate, the reason for termination, and a reasonable opportunity of at least thirty (30) calendar days to develop and implement a corrective action plan to correct the deficiencies; and/or
    - 5.5.5.2.2. Notify the CICO of its Appeal rights as provided in 42 C.F.R. § 422 Subpart N and § 438.710.
- 5.5.6. Termination due to a Change in Law
  - 5.5.6.1. In addition, CMS or SCDHHS may terminate this Contract upon thirty (30) calendar days' notice due to a material change in law, or with less or no notice if required by law.
- 5.5.7. Continued Obligations of the Parties
  - 5.5.7.1. In the event of termination, expiration, or non-renewal of this Contract, or if the CICO otherwise withdraws from the Medicare or South Carolina Medicaid programs, the CICO shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the CICO's Plan. CMS and SCDHHS will disenroll all Enrollees by the end of the month that termination, expiration, or non-renewal of this contract is effective.
  - 5.5.7.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:
    - 5.5.7.2.1. If CMS or SCDHHS, or both, elect to terminate or not renew the Contract, CMS and SCDHHS will be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive care. If the CICO elects to terminate or not renew the Contract, the CICO will be responsible for notifying all Enrollees and the general public, in accordance with federal and state requirements;
    - 5.5.7.2.2. The CICO must promptly return to CMS and SCDHHS all payments advanced to the CICO for Enrollees after the effective date of their disenrollment; and

- 5.5.7.2.3. The CICO must supply to CMS and SCDHHS all information necessary for the payment of any outstanding claims determined by CMS and SCDHHS to be due to the CICO, and any such claims will be paid in accordance with the terms of this Contract.

## 5.6. Order of Precedence

### 5.6.1. Order of Precedence Rules

- 5.6.1.1. The following documents are incorporated into and made a part of this Contract, including all appendices:
  - 5.6.1.1.1. Capitated Financial Alignment Application, a document issued by CMS and subject to modification each program year
  - 5.6.1.1.2. Memorandum of Understanding, a document between CMS and the State of South Carolina Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees (October 25, 2013);
  - 5.6.1.1.3. South Carolina Dual Eligible Demonstration Perspective CICO Qualification Screening;
  - 5.6.1.1.4. The CICO's response to the South Carolina Dual Eligible Demonstration Perspective CICO Qualification Screening; and
  - 5.6.1.1.5. Any State or Federal Requirements or Instructions released to Medicare-Medicaid Plans. Examples include the annual rate report, Medicare-Medicaid Marketing Guidance, Enrollment Guidance, and Reporting Requirements.
- 5.6.1.2. In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:
  - 5.6.1.2.1. The Contract terms and conditions, including all appendices;
  - 5.6.1.2.2. Capitated Financial Alignment Application;
  - 5.6.1.2.3. The Memorandum of Understanding between CMS and South Carolina;

- 5.6.1.2.4. South Carolina Dual Eligible Demonstration Perspective CICO Qualification Screening;
  - 5.6.1.2.5. The CICO's response to the South Carolina Dual Eligible Demonstration Perspective CICO Qualification Screening; and
  - 5.6.1.2.6. Any special State or Federal Requirements or Instructions released to Medicare-Medicaid Plans. Examples include the annual rate report, Medicare-Medicaid Marketing Guidance, and Enrollment Guidance.
- 5.6.1.3. In the event of any conflict between this Contract and the MOU, the Contract shall prevail.

## 5.7. Contract Term

### 5.7.1. Contract Effective Date

- 5.7.1.1. This Contract shall be in effect starting on the date on which all Parties have signed the Contract and shall be effective, unless otherwise terminated, through December 31, 2015. The Contract shall be renewed in one-year terms through December 31, 2017, so long as the CICO has not provided CMS and the SCDHHS with a notice of intention not to renew, pursuant to 42 C.F.R. § 422.506 or Section 5.5, above.
- 5.7.1.2. At the discretion of CMS and upon notice to the Parties, this Contract may be terminated, or the effectuation of the Contract Operational Start Date may be delayed, if South Carolina has not received all necessary approvals from CMS or, as provided in Section 2.2.1.3 of this Contract, if the CICO is determined not to be ready to participate in the Demonstration.
- 5.7.1.3. South Carolina may not expend Federal funds for, or award Federal funds to, the CICO until South Carolina has received all necessary approvals from CMS. South Carolina may not make payments to CICO by using Federal funds, or draw Federal Medical Assistance Payment (FMAP) funds, for any services provided, or costs incurred, by CICO prior to the later of the approval date for any necessary State Plan and waiver authority, the Readiness Review approval, or the Contract Operational Start Date.

## 5.8. Amendments

### 5.8.1. Amendment Process

- 5.8.1.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein.
- 5.8.1.2. By mutual agreement, the parties may amend this Contract where such amendment does not violate federal or State statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto.

5.9. Written Notices

5.9.1. Contacts

- 5.9.1.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to the contacts in this Section. Copies may be delivered to the designated entities by email at the discretion of the sender.

5.9.1.2. CMS:

To	Centers for Medicare and Medicaid Services Medicare-Medicaid Coordination Office 7500 Security Boulevard, S3-13-23 Baltimore, MD 21244
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5.9.1.3. South Carolina Department of Health and Human Services:

To	Health Services 1801 Main Street Columbia, SC 29201
Copies to:	Health Services 1801 Main Street Columbia, SC 29201 prime@scdhhs.gov

5.9.1.4. The CICO (<Entity>):

To	
Copies to:	



**Section 6. Signatures**

In Witness Whereof, CMS, SCDHHS, and <Entity> (the CICO) have caused this Agreement to be executed by their respective authorized officers:

---

<Signatory Name & Title>

---

Date

<Entity>

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In Witness Whereof, CMS, SCDHHS, and <Entity> (the CICO) have caused this Agreement to be executed by their respective authorized officers:

---

Anthony Keck, Director

---

Date

South Carolina  
Department of Health and Human Services (SCDHHS)

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In Witness Whereof, CMS, SCDHHS, and <Entity> (the CICO) have caused this Agreement to be executed by their respective authorized officers:

---

Jackie Glaze  
Associate Regional Administrator  
Centers for Medicare & Medicaid Services  
United States Department of Health and Human Services

---

Date

---

Kathryn Coleman  
Acting Director  
Medicare Drug & Health Plan Contract Administration Group  
Centers for Medicare & Medicaid Services  
United States Department of Health and Human Services

---

Date

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## APPENDIX A. Covered Services

- A.1 Medical Necessity: The CICO shall provide services to Enrollees as follows:
- A.1.1 Authorize, arrange, coordinate, and provide to Enrollees all Medically Necessary Covered Services as specified in Section 2.4, in accordance with the requirements of the Contract.
  - A.1.2 Provide all Covered Services that are Medically Necessary, including, but not limited to, those Covered Services that:
    - A.1.2.1 Prevent, diagnose, or treat health impairments;
    - A.1.2.2 Attain, maintain, or regain functional capacity.
  - A.1.3 Not arbitrarily deny or reduce the amount, duration, or scope of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee.
  - A.1.4 Not deny authorization for a Covered Service that the Enrollee or the Provider demonstrates is Medically Necessary.
  - A.1.5 The CICO may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of UM, provided that the furnished services can reasonably be expected to achieve their purpose. The CICO's Medical Necessity guidelines must, at a minimum, be:
    - A.1.5.1 Developed with input from practicing physicians in the CICO's Service Area;
    - A.1.5.2 Developed in accordance with standards adopted by national accreditation organizations;
    - A.1.5.3 Developed in accordance with the definition of Medical Necessity in Section 1;
    - A.1.5.4 Updated at least annually or as new treatments, applications and technologies are adopted as generally accepted professional medical practice;
    - A.1.5.5 Evidence-based, if practicable; and,
    - A.1.5.6 Applied in a manner that considers the individual health care needs of the Enrollee.
  - A.1.6 The CICO's Medical Necessity guidelines, program specifications and service components for Behavioral Health services must, at a minimum, be submitted to SCDHHS annually for approval no later than 30 calendar days prior to the

start of a new Contract Year, and no later than 30 calendar days prior to any change.

A.1.7 The CICO must offer to Enrollees any additional non-medical programs and services available to a majority of the CICO's commercial population, if any, on the same terms and conditions on which those programs and services are offered to the commercial population, unless otherwise agreed upon in writing by SCDHHS and the CICO, such as health club discounts, diet workshops and health seminars. The CICO's capitation rate shall not include the costs of such programs and services.

A.1.8 Offer and provide to all Enrollees any and all non-medical programs and services specific to Enrollees for which the CICO has received SCDHHS approval.

A.2 Covered Services: The CICO agrees to provide Enrollees access to the following Covered Services:

A.2.1 All services provided under South Carolina State Plan Services, excluding those services otherwise excluded or limited in A.4 of this Appendix.

A.2.2 All services provided under Medicare Part A

A.2.3 All services provided under Medicare Part B

A.2.4 All services provided under Medicare Part D

A.2.5 Demonstration specific-benefits, including:

A.2.5.1 As part of the Demonstration, Enrollees will be eligible to receive a Palliative Care benefit with a focus of pain management and comfort care. This benefit will optimize the quality of life of Enrollees living with a serious, chronic or life-limiting illness who may not meet the hospice criteria, including (but not limited to): Parkinson's disease, Multiple Sclerosis, Alzheimer's disease and/or dementia, end stage cancers, chronic obstructive pulmonary disease (COPD), Huntington's chorea, advanced liver disease, amyotrophic lateral sclerosis (ALS) ; and having a history of hospitalizations, a history of acute care utilization for pain and/or symptom management, or based on the recommendation of a physician or the multidisciplinary team.

A.2.6 Pharmacy products that are covered by SCDHHS and may not be covered under Medicare Part D, including:

A.2.6.1 Over-the-counter (OTC) drugs that are rebateable, as specified in [SCDHHS Pharmacy Services Manual](#)



<https://www.scdhhs.gov/provider-type/pharmacy-services-manual-020105-edition-posted-1142005>).

- A.2.6.2 Barbiturates for indications not covered by Part D (butalbital, mephobarbital, phenobarbital secobarbital);
- A.2.6.3 “Miscellaneous” drugs for indications that may not be covered by Part D (dronabinol, megestrol, oxandrolone, somatropin); and
- A.2.6.4 Prescription vitamins and minerals.
- A.2.6.5 CICOs are encouraged to offer a broader drug formulary than minimum requirements.

### A.3 Cost sharing for Covered Services

#### A.3.1 Medicare Services

- A.3.1.1 Except as described in Section A.3.2, cost-sharing of any kind is not permitted in this Demonstration.
- A.3.1.2 Co-pays charged by the CICO for Part D drugs must not exceed the applicable amounts for brand and generic drugs established yearly by CMS under the Part D Low Income Subsidy.
- A.3.1.3 The CICO may establish lower cost-sharing for prescription drugs than the maximum allowed.

#### A.3.2 Medicaid Services

- A.3.2.1 For Medicaid services beyond the pharmacy cost sharing described here, the CICO will not charge cost sharing to Enrollees above levels established under the State Plan.
- A.3.2.2 The CICO is free to waive Medicaid cost sharing.
- A.3.2.3 For Enrollees who are residents of nursing facilities, the CICO may require the Enrollee to contribute to the cost of nursing facility care that amount listed for the Enrollee on the Department’s patient credit file, which will be transmitted monthly to the Demonstration Plan.

### A.4 Limitations on Covered Services. The following services and benefits shall be limited as Covered Services:

- A.4.1 Termination of pregnancy may be provided only as allowed by applicable state and federal law and regulation (42 C.F.R. Part 441, Subpart E).

A.4.2 Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F).

**APPENDIX B. Covered Services Definitions**

In addition to all Medicare services, the Contractor is responsible for providing Medicaid covered benefits described below. All benefit limits for Medicaid covered services should be verified through the State Plan for Medicaid and the appropriate SCDHHS Provider Manual. The Contractor shall provide Medicare benefits as defined by CMS and its contractors.

Service	CFR, SPA or SCDHHS Manual Reference	Carved In or Carved Out	Notes
Skilled Nursing Facility	State Plan, Attachment 3.1-A Limitation Supplement page 1a	Carved In	<p>A system of health and social services designed to serve individuals who have functional limitations which impair their ability to perform activities of daily living (ADLs).</p> <p>It is care or services provided in a facility that is licensed as a nursing facility, or hospital that provides swing bed or Administrative Days.</p>
Home Health Services	State Plan, Attachment 3.1-A Limitation Supplement page 4b	Carved In	<p>Home health services are those services provided by a home health agency or individual provider to eligible beneficiaries who are affected by illness or disability. Home health services are based on physician’s orders and services are rendered by a health care professional.</p> <p>A visit is a face-to-face encounter between a patient and any qualified home health professional whose services are reimbursed under the Medicaid program. When care is provided, the service a patient receives is counted in visits.</p> <p>For example, if a patient receives one home health service twice in the same day or two different types of home health services in the same day, two visits would be counted.</p>
Durable Medical Equipment	State Plan, Attachment 3.1-A Limitation Supplement page 6	Carved In	As defined by SCDHHS, Durable Medical Equipment is 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. This equipment can withstand repeated use, is primarily and customarily used for medical purposes, and is appropriate

			and suitable for use in the home. Durable Medical Equipment includes equipment such as wheelchairs, hospital beds, traction equipment, canes, crutches, walkers, ventilators, oxygen, prosthetic and orthotic devices, and other medically needed items.
Prosthetics/Medical Supplies	State Plan, Attachment 3.1-A Limitation Supplement page 6	Carved In	<p>Prosthetic appliances replace all or part of the function of a permanently inoperative or malfunctioning body organ. Related supplies are covered when the appliances are essential to the effective use of the artificial limb. Coverage of prosthetic appliances includes repair or replacement of Medicaid-covered prosthetic devices (other than dental and eyeglasses).</p> <p>Medical supplies sponsored by Medicaid are items that, due to their therapeutic or diagnostic characteristics, are essential in enabling home health personnel to carry out effectively the care that the physician has ordered for the treatment or diagnosis of the patient's illness or injury.</p> <p>Certain items that by their very nature are designed only to serve a medical purpose are obviously considered to be medical supplies (e.g., catheters, needles, syringes, surgical dressing, and material used in aseptic techniques). Other medical supplies include, but are not limited to, irrigating solutions, intravenous fluids, and colostomy supplies.</p>
Meal Benefits	<p>1915(c) Home and Community-Based Services Waiver, Appendix C – Participant Services:</p> <ul style="list-style-type: none"> <li>• Community Choices</li> <li>• HIV/AIDS</li> <li>• Ventilator Dependent</li> </ul>	Carved In	Nutritionally sound meals are delivered to clients at their homes. Based on a physician's orders, meals may include standard diets or therapeutic and/or modified diets. All menus must be reviewed and approved by a registered dietitian and meals must be prepared and delivered according to the standards developed by CLTC.

Family Planning	State Plan, Attachment 3.1-A Limitation Supplement	Carved In	<p>Family Planning services may be prescribed and rendered by physicians, hospitals, clinics, pharmacies, or other Medicaid providers recognized by state and federal laws and enrolled as a Medicaid provider. Services include a Family Planning yearly exam, birth control, permanent sterilization procedures (vasectomy and tubal ligation), lab tests, and the first treatment for some sexually transmitted infections.</p> <p>Covered services include preventive contraceptive methods such as IUDs, sterilizations, diaphragms, condoms, sponges, Depo-Provera® injections, etc.</p>
Home and Community Based Services – Community Long Term Care	<p>1915(c) Home and Community-Based Services Waiver, Appendix C – Participant Services:</p> <ul style="list-style-type: none"> <li>• Community Choices</li> <li>• HIV/AIDS</li> <li>• Ventilator Dependent</li> </ul>	Carved In	<p>The mission of Community Long-Term Care (CLTC) is to provide a cost-effective alternative to institutional placement for eligible clients with long-term care needs, if they choose, allowing them to remain in a community environment. The South Carolina Department of Health and Human Services (SCDHHS) Division of Community Long-Term Care operates several waiver programs, including the Community Choices, HIV/AIDS, and Ventilator Dependent waiver.</p>
Personal Care Services (Personal Care I and II)	State Plan, Attachment 3.1-A Limitation Supplement page 6d	Carved In	<p>Personal Care I (PC I) services are designed to help preserve a safe and sanitary home environment, provide short-term relief for caregivers, and assist clients with personal care. These services supplement, but do not replace, the care provided to clients. The kinds of services performed by the PC I aide include the following:</p> <ul style="list-style-type: none"> <li>• Meal planning and preparation</li> <li>• General housekeeping</li> <li>• Assistance with shopping</li> <li>• Companion or sitter services</li> </ul>

			<ul style="list-style-type: none"> <li>• Assistance with financial matters, such as delivering payments to designated recipients on behalf of the client</li> <li>• Assistance with communication</li> <li>• Observing and reporting on the client's condition</li> </ul> <p>Personal Care II (PC II) services are designed to help clients with normal daily activities and to monitor the medical conditions of functionally impaired/disabled clients. The kinds of activities that the PC II aide performs are comparable to those that family members would perform for the person in need. PC II aides provide assistance with walking, bathing, dressing, toileting, grooming, preparing meals, and feeding. The aide also helps to maintain the home environment, including light cleaning, laundry, shopping, and keeping the home safe.</p> <p>The client's vital signs, such as respiratory rate, pulse rate, and temperature, are observed. The aide may also remind the client to take prescribed medication(s) and, when necessary, transport and/or escort the client.</p> <p>PC II aides work under the supervision of an RN or LPN in the client's home. Under no circumstances may a PC II aide perform any type of skilled medical service. PC II aides who provide services to HIV/AIDS clients should be trained in infection control. The Centers for Disease Control and Prevention (CDC) precautions must be followed when rendering care to protect the client and the PC II aide.</p>
Private Duty Nursing	State Plan, Attachment 3.1-A page 3a	Carved In	Nursing services provide skilled medical monitoring, direct care, and interventions that meet the medical needs of the client with HIV/AIDS, and individuals on a mechanical ventilator, at home. The client's condition may require 24-hour continuous care for a short duration due to an episodic condition.

Case Management for Long Term Care	<p>1915(c) Home and Community-Based Services Waiver, Appendix C – Participant Services:</p> <ul style="list-style-type: none"> <li>• Community Choices</li> <li>• HIV/AIDS</li> </ul>	Carved In	<p>CLTC case management is a vital part of the long-term care program that is provided for all waiver clients.</p> <p>Case management ensures continued access to the long-term care program. It also enables case managers to advise, support, and assist clients and their families in coping with changing needs and in making decisions regarding long-term care. Case management includes the following five activities: service counseling, service planning, service coordination, monitoring, and re-evaluating.</p>
IMD for 65+	State Plan, Attachment 3.1-A Limitation Supplement page 6e	Carved In	<p>An institution for mental disease (IMD) is defined as an institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether a facility is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases.</p>
Case Management	State Plan, Attachment 3.1-A Limitation Supplement page 7b through 8z.1	Carved In	<p>Medicaid Targeted Case Management (MTCM) is a means for achieving beneficiary wellness through communication, education and services identification and referral. MTCM provides an organized structured process for moving beneficiaries through the process of change and toward the goal of self-sufficiency.</p> <ul style="list-style-type: none"> <li>• The MTCM process is a shared partnership between the beneficiary and/or responsible party and the case manager.</li> <li>• Beneficiaries and/or responsible parties are actively involved in all phases of the process – assessment, planning, problem solving and identification of resources.</li> <li>• MTCM ensures available resources are being used in a timely and cost effective manner.</li> </ul>

Health Education	State Plan, Attachment 3.1-A Limitation Supplement page 7a.5	Carved In	<p>The target population is any Medicaid-eligible beneficiary with diabetes who meets the criteria for participation in the Diabetes Management Services Program. The program, based on the target population's needs, must offer instruction in the following content areas:</p> <ul style="list-style-type: none"> <li>• Monitoring blood glucose and urine ketones (when appropriate), and using the results to improve control</li> <li>• Promoting preconception care, management during pregnancy, and gestational diabetes management (if applicable)</li> <li>• Describing the diabetes disease process and treatment options</li> <li>• Incorporating appropriate nutritional management education</li> <li>• Incorporating physical activities into the diabetic patient's lifestyle</li> <li>• Utilizing medications (if applicable) for therapeutic effectiveness</li> <li>• Preventing, detecting, and treating acute/chronic complications</li> <li>• Preventing (through risk-reduction behavior) and detecting complications</li> <li>• Goal setting to promote health and problem solving for daily living</li> <li>• Integrating psychosocial adjustment into one's daily life</li> </ul> <p>The program must use instruction methods and materials appropriate for the target population.</p>
Behavioral Health Services (Rehabilitative Behavioral Health)	State Plan, Attachment 3.1-A Limitation Supplement page 6b through 6c.16	Carved In	<p>Rehabilitative Services are available to all Medicaid beneficiaries with a Behavioral health and/or Substance use disorder, as defined by the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD) who meet medical necessity criteria. Rehabilitative services are provided to, or directed exclusively, toward</p>



			the treatment of the Medicaid-eligible beneficiary for the purpose of ameliorating disabilities, improving the beneficiary's ability to function independently, and restoring maximum functioning through the use of diagnostic and restorative services.
Outpatient Mental Health Services (Community mental health services)	State Plan, Attachment 3.1-A Limitation Supplement page 5a	Carved In	<p>Community mental health services are provided to adults and children diagnosed with a mental illness as defined by the current edition of the Diagnostic Statistical Manual (DSM). Clinic services are preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services that meet all of the following criteria:</p> <ul style="list-style-type: none"> <li>• Services provided to outpatients</li> <li>• Services provided by a facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients</li> <li>• Services furnished by or under the direction of a physician</li> </ul>
Infusion Centers/Services	Clinic Services Manual 11/01/05	Carved In	<p>Infusion therapies must be ordered by a physician and administered by a licensed physician or licensed nurse acting within the scope of laws governing his or her professional practice limits</p> <ul style="list-style-type: none"> <li>• Each infusion therapy code is reimbursed at an all-inclusive rate that includes but is not limited to: <ul style="list-style-type: none"> <li>○ All items and services necessary to provide therapy treatment</li> <li>○ Supplies</li> <li>○ Equipment</li> <li>○ Professional and ancillary personnel</li> </ul> </li> </ul> <p>Injectable drugs may be billed in addition to the therapy codes.</p>
Residential Personal Care Services	1915(c) Home and Community-Based Services Waiver,	Carved In	Residential habilitation services include the care, skills, training, and supervision provided to clients in a non-institutional setting. The degree and type of care, supervision, skills training, and support of clients will

	<p>Appendix C – Participant Services:</p> <ul style="list-style-type: none"> <li>• Community Choices</li> <li>• Ventilator Dependent</li> </ul>		<p>be based on the plan of service and the client’s individual needs. Services include assistance with the following:</p> <ul style="list-style-type: none"> <li>• The acquisition, retention, or improvement of skills related to activities of daily living, such as personal grooming and cleanliness</li> <li>• Household chores and bed-making</li> <li>• Eating and preparation of food</li> <li>• Social and adaptive skills necessary to enable the individual to reside in a non-institutional setting</li> </ul>
Nursing Home Transition Services (Home Again)	CLTC Provider Manual 02/01/05 Edition	Carved In	<p>The goal of Nursing Home Transition Services is to properly identify and transition current nursing home residents who desire to return to the community. The services assist elderly individuals with disabilities and clients with mental health conditions. The following one-time services are available for clients transitioning to a community waiver program from a nursing home:</p> <ul style="list-style-type: none"> <li>• Appliances: This service is intended to provide necessary appliances</li> <li>• Furniture procurement: Funds are used to purchase minimal furnishings necessary to establish a home in the community.</li> <li>• Rent/utility assistance: One-time rent/utility assistance is available for clients who need financial help to secure a community residence.</li> </ul> <p>Participants receiving Nursing Home Transition Services must meet criteria for Home Again program.</p>
Respite Care	1915(c) Home and Community-Based Services Waiver, Appendix C – Participant	Carved In	<p>Respite care services are intended to provide temporary around-the-clock relief for caregivers by placing the client in an institutional setting for up to fourteen days per state fiscal year. The provider of respite care services must be licensed and certified by South Carolina Department of</p>

	<p>Services:</p> <ul style="list-style-type: none"> <li>• Community Choices</li> <li>• Ventilator Dependent</li> </ul>		<p>Health and Environmental Control (DHEC), as a hospital, nursing home, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). Out-of-state providers must be licensed by an equivalent agency of that state. They must also have a valid Medicaid contract with the SCDHHS.</p>
Adult Day Health Services	<p>1915(c) Home and Community-Based Services Waiver, Appendix C – Participant Services:</p> <ul style="list-style-type: none"> <li>• Community Choices</li> </ul>	Carved In	<p>Based on the client’s identified needs, Adult Day Health Care centers provide a range of health care and support services. The center provides planned therapeutic activities to stimulate mental activity, communication, and self-expression. The center staff provides meals and supervision of personal care. The center also transports clients to and from home, if they live within fifteen miles of the center. With special approval, the center may also provide additional services.</p> <p>A limited number of skilled procedures are available to persons receiving Adult Day Health Care. A licensed nurse, as ordered by a physician, provides the skilled procedures in the Adult Day Health Care center.</p> <p>Nursing care is provided to:</p> <ul style="list-style-type: none"> <li>• Monitor the client’s vital signs and ability to function</li> <li>• Supervise intake of medication and possible reactions</li> <li>• Teach health care and self-care</li> <li>• Oversee treatment in conjunction with a client’s physician and case manager</li> </ul> <p>The DHEC or the equivalent licensing agency for out-of-state facilities, must license all adult day care centers. Furthermore, centers must have adequate procedures for medical emergencies and must meet the minimum staffing requirements as specified by the contract.</p>
Environmental	1915(c) Home and Community-Based	Carved In	Environmental modification services provide pest control and physical adaptations or modifications to the home that are necessary to ensure the

Modifications	<p>Services Waiver, Appendix C – Participant Services:</p> <ul style="list-style-type: none"> <li>• Community Choices</li> <li>• HIV/AIDS</li> <li>• Ventilator Dependent</li> </ul>		<p>health, welfare, and safety of the client. Environmental modifications enable clients to function with greater independence in the home. An example of such a modification is the construction of a ramp.</p> <p>All environmental modification providers must have a residential or general contractor’s license to provide services. In addition to this requirement providers must have general liability and workers compensation insurance.</p>
Tele-psychiatry	State Plan, Attachment 3.1-A Limitation Supplement page 5a	Carved In	<p>Psychiatric diagnostic evaluations with medical services formally known as Psychiatric Medical Assessments are face-to-face clinical interactions between a client and a physician, or advanced practice registered nurse, or tele-psychiatry to assess and monitor the client’s psychiatric and/or physiological status for one or more of the following purposes:</p> <ul style="list-style-type: none"> <li>• Assess the mental status of a client and provide a psychiatric diagnostic evaluation, including the evaluation of concurrent substance use disorders</li> <li>• Provide specialized medical, psychiatric, and/or substance use disorder assessment</li> <li>• Assess the appropriateness of initiating or continuing the use of medications, including medications treating concurrent substance use disorders</li> <li>• Provide or review information on which to base a psychiatric evaluation and establish the medical necessity for care</li> <li>• Assess or monitor a client’s status in relation to treatment</li> <li>• Assess the need for a referral to another health care, substance abuse, and/or social service provider</li> <li>• Diagnose, treat, and monitor chronic and acute health problems.</li> </ul>

			<p>This may include completing annual physicals and other health maintenance care activities such as ordering, performing, and interpreting diagnostic studies such as lab work and x-rays.</p> <ul style="list-style-type: none"> <li>• Plan treatment and assess the need for continued</li> <li>• treatment</li> </ul> <p>Delivery of this service may include contacts with collateral persons for the purpose of securing pertinent information necessary to complete an evaluation of the client.</p> <p>When provided by a physician, Psychiatric Diagnostic Evaluations (PDE) can be rendered via interactive telecommunication. All other requirements must be met to render this service.</p> <p>Services that are eligible for reimbursement include consultation, office visits, individual psychotherapy, pharmacologic management and psychiatric diagnostic interview examinations and testing delivered via telecommunication system. Providers must be a Physician or NP. Services included are office visits, inpatient consultation, individual psychotherapy, pharmacologic management, psychiatric diagnostic interview examination, neurobehavioral status exam, electrocardiogram interpretation and report only, echocardiography. Services such as telephone conversations, email messages and video cell phone interactions are not covered.</p> <p>Telespsychiatry is only provided through the Department of Mental in partnership with 20+ hospital emergency rooms in the state.</p>
Companion Services	<p>1915(c) Home and Community-Based Services Waiver, Appendix C – Participant Services:</p> <ul style="list-style-type: none"> <li>• Community Choices</li> </ul>	Carved In	Companion services provide short-term relief for caregivers and supervision of clients.

	<ul style="list-style-type: none"> <li>• HIV/AIDS</li> </ul>		
Self-Directed Personal Assistance (Attendant Care)	<p>1915(c) Home and Community-Based Services Waiver, Appendix C – Participant Services:</p> <ul style="list-style-type: none"> <li>• Community Choices</li> <li>• HIV/AIDS</li> <li>• Ventilator Dependent</li> </ul>	Carved In	<p>Attendant care services are provided by qualified individuals to help clients by offering support for activities of daily living and monitoring the medical condition of clients. The kinds of activities that an attendant provider performs include the following:</p> <ul style="list-style-type: none"> <li>• Assistance with personal hygiene, feeding, bathing, and meal preparation</li> <li>• Encouraging clients to adhere to specially prescribed diets</li> <li>• General housekeeping duties</li> <li>• Shopping assistance</li> <li>• Assistance with communication</li> <li>• Monitoring medication</li> </ul> <p>Supervision may be furnished directly by the client when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by an RN or otherwise as provided within state law. This certification must be based on actual observation of the client and the specific attendant care provider during the actual provision of care.</p>
Adult Day Health Transportation	State Plan, Attachment 3.1-A Limitation Supplement 9h	Carved In	Allows for the transport of clients to and from home, to the center, if they live within fifteen miles of the center. With special approval, the center may also provide additional services.
Two Additional Prescription Drug Benefit	1915(c) Home and Community-Based Services Waiver, Appendix C – Participant Services:	Carved In	Those individuals enrolled in the HIV/AIDS or Ventilator Dependent waiver programs are allowed two additional prescriptions per month above the current monthly limit.

	<ul style="list-style-type: none"> <li>• HIV/AIDS</li> <li>• Ventilator Dependent</li> </ul>		
Non-emergent Transportation Services	State Plan, Attachment 3.1-A Limitation Supplement page 9d	Carved Out	<p>The broker will provide Medicaid transportation services for the following:</p> <ul style="list-style-type: none"> <li>• All non-emergency ambulance transportation to medical appointments and non-emergency transports which are planned/scheduled trips.</li> <li>• Transports from a nursing home to a physician's office, a nursing home to a dialysis center, or hospital to residence.</li> <li>• Non-emergency transportation for beneficiaries requiring stretcher or wheelchair service.</li> <li>• Non-emergency transportation services to beneficiaries traveling out of state for prior authorized medical services, (e.g., lodging, meals, etc.).</li> <li>• Non-emergency air transports for both Rotary and Fixed Wing air flights.</li> <li>• Transportation for beneficiaries who receive retroactive eligibility.</li> </ul>
Adult Dental	State Plan, Attachment 3.1-A Limitation Supplement page 5a	Carved Out	Diagnostic services include the oral examination, and selected radiographs needed to assess the oral health, diagnose oral pathology, and develop an adequate treatment plan for the member's oral health.
Pharmacy Services	Attachment 3.1-A Limitation Supplement page 5b	Carved In	The SCDHHS requires that providers of pharmacy services to South Carolina Medicaid beneficiaries adhere to all state and federal requirements regarding the practice of pharmacy. Additionally, South Carolina Medicaid-enrolled pharmacies located outside of the state of South Carolina must adhere to all federal and state requirements specific to the state in which the pharmacy is located.

Hospice Services	State Plan, Attachment 3.1-A page 7	Carved Out	A hospice is a public agency or private organization or a subdivision of either of these that is primarily engaged in providing care and services to terminally ill individuals, meets the Medicare conditions of participation for hospices, and has a valid provider contract. Hospice coverage for South Carolina Medicaid beneficiaries is available for an unspecified number of days, subdivided into election periods as follows: two periods of 90 days each, and an unlimited number of subsequent periods of 60 days each. Benefit periods can be used consecutively or at different times during the beneficiary's life span. At the beginning of each period, the beneficiary must be certified by a physician as terminally ill with a life expectancy of six months or less.
Dialysis for End-Stage Renal Disease (ESRD)	State Plan, Attachment 3.1-A Limitation Supplement page 5	Carved In	<p>Medicaid reimburses the nephrologist or other supervising internist an all-inclusive monthly fee for the supervision of ESRD services. These services are defined as monthly supervision of medical care, dietetic services, social services, and procedures directly related to the physician's role in the treatment of end stage renal disease.</p> <p>If an ESRD patient is hospitalized, the hospitalization may or may not be due to a renal-related condition. In either case, the patient must continue dialysis.</p>



## APPENDIX C. Transition of Home and Community Based Services

- C.1 SCDHHS's service delivery model includes a transition of HCBS responsibilities to the CICO during the Demonstration period. This section describes the plan for transition of HCBS authority to CICOs and details the activities, responsibilities and benchmarks for each transition phase.
  - C.1.1 Phase I of the transition (January 1 to April 30, 2015) closely resembles the operations of SCDHHS's current HCBS system and is considered a time to transfer knowledge of this system to the CICOs.
  - C.1.2 Phase II (May 1 to December 31, 2015) begins the transition of the system's functions that were previously performed by SCDHHS to the CICOs. This phase is designed to support the activities necessary to positively influence the continued integration of HCBS.
  - C.1.3 Phase III (calendar year 2016) concludes the total transformation of SCDHHS's HCBS system. At this point, the CICOs assume all the responsibilities, including self-direction, needed to continue to adequately coordinate these services.
- C.2 Benchmark Review
  - C.2.1 The CICO must pass an HCBS benchmark review prior to assuming the responsibilities of Phase II or Phase III. Benchmark reviews will be conducted by SCDHHS staff and its agent. Failure to adequately address the benchmark standards could preclude the CICO from moving forward to the next phase of the HCBS transition and may impact a CICO's eligibility for future passive enrollment.
  - C.2.2 Review Timing
    - C.2.2.1 Benchmark Review in Preparation for Phase II
      - C.2.2.1.1 Review will occur March 1, 2015
      - C.2.2.1.2 SCDHHS will make a decision as to the CICO's readiness no later than April 30, 2015.
    - C.2.2.2 The Benchmark Review Period in Preparation for Phase III
      - C.2.2.2.1 Review will occur October 1 – 31, 2015
      - C.2.2.2.2 SCDHHS will make a decision as to the CICO's readiness no later than November 15, 2015.
    - C.2.2.3 If the CICO fails to adequately meet the benchmark standards, a corrective action plan, including specific dates, must be submitted

to the review team within 48 hours of receipt of the report of findings.

C.3 A summary of the respective SCDHHS and CICO roles and responsibilities over the course of the transition can be found in the Exhibit below.

**Exhibit 4 Overview of SCDHHS/CICO Responsibilities during HCBS Transition**

Functions	Phase I	Phase II	Phase III
Use of Phoenix and <i>Care Call</i>	SCDHHS & CICO	SCDHHS & CICO	SCDHHS & CICO
Provider credentialing / monitoring	SCDHHS	SCDHHS	SCDHHS; CICO can choose to assume this responsibility at its own cost
HCBS Providers Contractual Authority	SCDHHS	CICO; SCDHHS provides a contract template and/or scope of service	CICO
HCBS care plan development	SCDHHS; CICOs have formal input process	CICO; SCDHHS concurrence required	CICO; SCDHHS concurrence required
Oversight of Waiver Case Manager’s participation in multidisciplinary team	CICO	CICO	CICO
HCBS Provider Rate Setting Authority	SCDHHS	CICO; SCDHHS establishes rate guidelines	CICO; SCDHHS establishes rate guidelines
HCBS claims processing (via <i>Care Call</i> ) and provider payments	CICO	CICO	CICO
LTC LOC Assessments	SCDHHS	SCDHHS	SCDHHS
LTC LOC Reassessment	SCDHHS	CICO	CICO
Self-directed attendant care and related functions	SCDHHS	SCDHHS	CICO

- C.4 SCDHHS will retain authority for the following functions for all beneficiaries requiring HCBS (both enrolled and not enrolled in the Demonstration) for the duration of the Demonstration:
- C.4.1 Initial Long Term Care Assessment,
  - C.4.2 Level of care determinations and re-determinations,
  - C.4.3 Guidelines for minimum rate levels,
  - C.4.4 HCBS provider credentialing/monitoring, and
  - C.4.5 Integration of SCDHHS's IT system (i.e., Phoenix/Care Call).
  - C.4.6 CICOs will have access to Phoenix/Care Call, SCDHHS's automated Case Management and service authorization systems.
- C.5 Phase I: January 1 to April 30, 2015:
- C.5.1 SCDHHS will continue to maintain direct contracting with HCBS providers during this four month period, including those who provide Case Management. CICOs will initiate HCBS network development during this phase with demonstrated network capacity by March 2015. Waiver Case Managers will be fully integrated into the Demonstration model through their participation in the multidisciplinary team and through the continued utilization of extensive data for evaluating Enrollee experiences, access, and utilization of services, assessments and care plans available through the Phoenix/Care Call system.
  - C.5.2 SCDHHS will retain the following HCBS responsibilities during Phase I:
    - C.5.2.1 *Contractual authority for all HCBS providers, including Case Management.* SCDHHS will continue to utilize its provider contracting processes for HCBS providers. Provider manuals, scopes of service and enrollment procedures will be shared with CICOs in preparation for assuming this responsibility in Phase II.
    - C.5.2.2 *Authority for Long Term Care Assessment.* SCDHHS will continue to utilize its automated HCBS assessment form in Phoenix. CICOs will be trained in conducting assessments and completing the form in preparation for assuming reassessment responsibilities in Phase II.
    - C.5.2.3 *Authority for initial level of care determinations and redeterminations.* The South Carolina Level of Care Criteria for Medicaid-Sponsored LTC will continue to serve as the medical/functional eligibility criteria for both waiver and nursing

facility services. The CICOs will be trained in how the criteria are applied for determining the need for LTSS services via the Long Term Care Assessment.

- C.5.2.4 *Authority for HCBS care plan development and service authorizations.* The CICOs will have formal input in 1915(c) care plans and service authorizations. For Enrollees receiving waiver services, SCDHHS will develop a formal mechanism for CICOs to participate in the care planning process through Phoenix and via teleconference or in person for more deliberative discussions. An arbitration process through the Demonstration's independent ombudsman will be established for disputes related to service authorizations and service levels to ensure that optimal community based services are provided in the best interest of the Enrollee
- C.5.2.5 *Rate setting authority.* SCDHHS will publicize a provider rate schedule utilized for HCBS and projections for provider rate increases during the Demonstration years that may be applicable in Phase II and Phase III.
- C.5.2.6 *Provider credentialing and monitoring authority throughout the Demonstration period.* SCDHHS will follow the credentialing and monitoring processes outlined in its 1915(c) waivers. For CICOs who express an interest in assuming this function in Phase III, detailed training will be provided on the processes and requirements employed by SCDHHS. However, only providers who are approved by SCDHHS will be allowed to participate in the Demonstration.
- C.5.2.7 *All administrative costs related to Phoenix/Care Call and the related financial management system.*

C.5.3 CICOs will undertake the following HCBS responsibilities during Phase I:

- C.5.3.1 *Use of Phoenix/Care Call.* CICOs will be mandated to use and interface with Phoenix/Care Call, including the financial management service that is a component of the Care Call contract. Prior to implementation, the CICO will work with SCDHHS to ensure the CICO's have the necessary access/ability to monitor and receive HCBS claims via the Phoenix/Care Call system for the CICO's Enrollees consistent with applicable privacy rules/regulations. SCDHHS will work with software developers to expand the functionality of the system for the CICOs by November 2014.

- C.5.3.2 *Ability to make LTSS referrals.* Whenever there is an indication that LTSS are needed, the CICO Care Coordinator will be expected to make an electronic referral through Phoenix.
- C.5.3.3 *Payment of HCBS claims via Care Call.* HCBS will be included in the capitation rate and CICOs will receive claims for Enrollees through the Care Call system. Care Call is an automated system used in the three Medicaid waiver programs included in the Demonstration for the prior authorization of services, service documentation, service monitoring, web-based reporting, and billing to MMIS. SCDHHS will enhance Care Call's functionality to allow a data exchange of information to the CICOs for claims processing and payment purposes by January 2015. CICOs will pay HCBS providers in a timely manner prescribed by SCDHHS.
- C.5.3.4 *Oversight and management of the Waiver Case Manager's participation in their multidisciplinary team to ensure the integration of Medicare and Medicaid services.* Waiver case managers and other service providers will offer an additional level of in-home monitoring/observation and, via Care Call, pertinent information (e.g., changes in an Enrollee's condition such as difficulty walking, transferring, sleeping, skin breakdown, or memory issues) will be provided to the CICO Care Coordinator.
- C.5.3.5 *Development of measurable linkages between HCBS, primary care and behavioral health services through its care integration processes.* In order to ensure access to preventive health care and ongoing integration and management of primary, acute, behavioral health and LTSS, CICOs will adopt a care model for organizing and tracking health services; assign the same priority to a stable primary care home as to stable housing and medication adherence; assure that assessment of health status is an ongoing component of health services and that there is a high level of communication between behavioral health providers, LTSS providers, PCPs, and other care providers; develop relationships with care providers across primary, behavioral acute and LTSS care settings; and implement evidence-based practices for care delivery.
- C.5.3.6 *Building relationships with HCBS providers and incorporating these providers into their networks for contract implementation March 1, 2015.*
- C.5.4 CICO Benchmark Review Standards: In the month of October 2014, SCDHHS and its EQRO, in consultation with CMS, will conduct a series of benchmark reviews. During this review, the CICOs must demonstrate the following:

- C.5.4.1 *Case Management and RN assessor staffing competencies in conducting reassessments.*
- C.5.4.2 *Network capacity for HCBS Case Management and all non-Case Management HCBS with the exception of self-directed attendant care.*
- C.5.4.3 *Ability to fully manage and integrate the full continuum of Medicare and Medicaid services as evidenced by the following:*
  - C.5.4.3.1 HCBS care coordination infrastructure;
  - C.5.4.3.2 Integration of HCBS into multidisciplinary team; and
  - C.5.4.3.3 Policies in support of these integrated functions.
- C.5.4.4 *Ability to process and pay claims in a timely manner.*
- C.5.4.5 *Proposed HCBS rate setting methodology for the aforementioned services for SCDHHS review.*
- C.5.4.6 *Understanding of the credentialing and monitoring process.*

C.6 Phase II: May 1 to December 31, 2015:

- C.6.1 Phase II is marked by the transition of core services from SCDHHS to the CICOs. During this phase, the roles and responsibilities outlined in Phase I are transitioned as the CICO assumes oversight and authority of HCBS care plan development, service authorization, and all HCBS provider contracts, except self-directed attendant care.
- C.6.2 CICO Responsibilities During Phase II: Effective May 1, 2015, CICOs will assume the following responsibilities:
  - C.6.2.1 *Authority to perform LOC reassessments.* (SCDHHS retains authority to perform all initial LOC assessments on new Enrollees for LTC services.)
  - C.6.2.2 *Formal contractual authority and programmatic oversight* with HCBS providers under the following conditions:
  - C.6.2.3 *Readiness:* CICOs must meet benchmark review standards for HCBS provider sufficiency.
    - C.6.2.3.1 *Network adequacy:* CICOs must have sufficient providers in each geographic area sufficient to meet the needs of the target population and to guarantee

Enrollees have a meaningful choice of providers for each service. Since the volume of and need for services differ, the number of providers will vary by specific services. For instance, more personal care providers are necessary to cover an area than adult day care providers or home delivered meals providers.

C.6.2.3.2 *Provider contracts:* CICOs will use a standard HCBS contract provided by SCDHHS during Phase II of the transition period to ensure consistent continuity of care standards are put into place.

C.6.2.3.3 *Provider rates:* CICOs will be able to set HCBS provider rates using pre-established guidelines from SCDHHS. CICOs must comply with rate floors adjusted annually for each service that will set a minimum reimbursement level. These floors will also allow CICOs to create incentives for performance and quality. Rates that fall below 100 percent of the current FFS should have a corresponding performance and/or quality incentive that should be reflective of 100 percent of the FFS rate (at a minimum).

C.6.2.4 *Authority for HCBS care plan development and service authorizations with SCDHHS concurrence.* An arbitration process through the Demonstration's independent ombudsman will continue to exist for disputes, should they arise. The ombudsman will advocate on behalf of the Enrollee's best interest.

C.6.2.5 *CICOs will retain claims processing and provider payments for all HCBS.* Self-directed care will be paid by the CICOs through SCDHHS's financial management service provider, PPL.

C.6.3 *CICO Benchmark Review Standards:* In October 2015, SCDHHS and its EQRO, in consultation with CMS, will conduct a final series of benchmark reviews. During this review, the CICOs must demonstrate the following:

C.6.3.1 *Competency to assume the authority to oversee self-directed attendant care through the:*

C.6.3.1.1 Incorporation of self-direction in care plans during Phases I and II;

C.6.3.1.2 Capacity to assess the viability of self-direction for Enrollees;

- C.6.3.1.3 Ability to interface with the University of South Carolina’s Center for Disability Resources which provides screening for attendants and employers; and
- C.6.3.1.4 Ability to promptly and adequately pay attendants. This process will continue to flow through SCDHHS’s established *Care Call* and financial management contractor, PPL system.

C.6.3.2 *Demonstrated understanding of provider credentialing and monitoring processes if a CICO elects to assume this optional responsibility.*

C.7 Phase III: Calendar year 2016:

C.7.1 Phase III is marked by the CICO’s maturity in HCBS operations and assumption of the remaining HCBS core components, care plan development, service authorization, self-directed attendant care and attendants, many of whom are paid family caregivers.

C.7.2 CICO Responsibilities During Phase III: Effective January 1, 2016, CICOs will assume the following additional responsibilities:

C.7.2.1 Responsibility for self-directed attendant care and related functions.

C.7.2.2 Independent provider credentialing and monitoring processes if a CICO elects to assume this option.

C.7.2.3 HCBS Provider Contracting

C.7.2.3.1 The oversight of HCBS providers will follow the process documented in the approved 1915 (c) waiver application. Solvency - CICOs will be required to meet solvency requirements:

C.7.2.3.2 Consistent with section 1903 (m) of the Social Security Act, and regulations found at 42 CFR § 422.402, and 42 CFR § 438.116, and;

C.7.2.4 As specified in the State laws, regulations and rules specified by the South Carolina Department of Insurance (DOI). The DOI is responsible for licensing and monitoring of the financial solvency of health maintenance organizations (HMOs). All Medicaid managed care providers are required by the State to be licensed by DOI as HMOs pursuant to Title 38, Chapter 33 of the SC Code of



Laws. CICOs must provide assurances satisfactory to the State showing that its provisions for insolvency meet state regulatory standards and are adequate to ensure its Medicaid Enrollees will not be liable for the entity's debts if the entity becomes insolvent.

- C.7.2.5 Credentialing and Practitioner Licensure Authorities and Application within Approved Contracts: CICO's must adhere to managed care standards at 42 CFR § 438.214 and 42 CFR § 422.204 and must be accredited by NCQA and follow NCQA procedural requirements for standards for credentialing and re-credentialing. In addition, CICOs must follow the State guidance and requirements listed below for Medicaid.
- C.7.2.6 The CICO provider network shall be comprised of a sufficient number of appropriately credentialed, licensed, or otherwise qualified providers to meet the requirements of the Three-Way Contract, to ensure access to all covered services, and that all providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the covered services;
- C.7.2.7 The CICO shall implement written policies and procedures that comply with the requirements of 42 CFR §422.204 and 438.214 regarding the selection, credentialing, retention, and exclusion of providers and meet, at a minimum, the requirements below in addition to those described in the Three-Way Contract. The CICO shall submit such policies and procedures annually to SCDHHS and demonstrate, by reporting annually, that all providers within the CICO's provider network are credentialed according to such policies and procedures. The CICO shall:
- C.7.2.8 Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers who participate in the CICO's provider network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards and relevant state regulations, including regulations issued by the South Carolina Department of Labor, Licensing and Regulation and the South Carolina Department of Health and Environmental Control;
- C.7.2.9 Ensure that all providers are credentialed prior to becoming network providers and that a site visit is conducted with recognized managed care industry standards and relevant state regulations;
- C.7.2.10 Maintain a documented re-credentialing process which shall occur regularly, as specified in the Three-Way Contract, and requires that physician providers and other licensed and certified professional

providers, including behavioral health providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform with recognized managed care industry standards;

- C.7.2.11 Upon notice from the State or CMS, not authorize any providers barred from participation in Medicaid, Medicare or from another state's Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided. In addition If a provider is terminated or suspended from the South Carolina Medicaid program, Medicare, or another state's Medicaid program or is the subject of a state or federal licensing action or for any other independent action, the CICO shall terminate, suspend, or decline a provider from its network as appropriate, and notify the State of such action.
- C.7.2.12 Not contract with, or otherwise pay for any items or services furnished, directed or prescribed by, a provider that has been excluded from participation in federal health care programs by the Office of the Inspector General of the United States Department of Health and Human Services under either Section 1128 or Section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901;
- C.7.2.13 Not establish provider selection policies and procedures that discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment;
- C.7.2.14 Ensure that no credentialed provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90, and M.G.L. Ch. 118E s. 40;and,
- C.7.2.15 Notify the State and CMS when a provider fails credentialing or re-credentialing because of a program integrity reason, and shall provide related and relevant information to the State and CMS as required by the State, CMS or state or federal laws, rules, or regulations.
- C.7.2.16 Board Certification Requirements

- C.7.2.16.1 The CICO shall maintain a policy with respect to board certification for primary care providers and

specialty physicians that ensures that the percentage of board certified primary care providers and specialty physicians participating in the provider network, at a minimum, is approximately equivalent to the community average for primary care providers and specialty physicians in the CICO's service area.

C.7.2.17 Laboratory Credentialing

C.7.2.17.1 The CICO shall require all laboratories performing services under the Three-Way Contract to comply with the Clinical Laboratory Improvement Amendments.

## **APPENDIX D. Enrollee Rights**

- D.1 The CICO must have written policies regarding the Enrollee rights specified in this appendix, as well as written policies specifying how information about these rights will be disseminated to Enrollees. Enrollees must be notified of these rights and protections at least annually, and in a manner that takes in to consideration cultural considerations, Functional Status and language needs. Enrollee rights include, but are not limited to, those rights and protections provided by 42 C.F.R. § 438.100, 42 C.F.R. §422 Subpart C, and Memorandum of Understanding (MOU) between CMS and SCDHHS to implement the Demonstration.
- D.2 Specifically, Enrollees must be guaranteed:
- D.2.1 The right to be treated with dignity and respect.
  - D.2.2 The right to be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law.
  - D.2.3 The right to be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records, as specified in 45 C.F.R. part 164.
  - D.2.4 The right not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment.
  - D.2.5 The right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed.
  - D.2.6 Access to an adequate network of primary and specialty providers who are capable of meeting the Enrollee's needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting.
  - D.2.7 The right to choose a plan and provider at any time, including a plan outside of the demonstration, and have that choice be effective the first calendar day of the following month.
  - D.2.8 The right to have a voice in the governance and operation of the integrated system, provider or health plan, as detailed in this three-way contract.
  - D.2.9 The right to participate in all aspects of care, including the right to refuse treatment, and to exercise all rights of appeal.

- D.2.10 Enrollees have a responsibility to be fully involved in maintaining their health and making decisions about their health care, including the right to have advanced directives and to refuse treatment if desired, and must be appropriately informed and supported to this end. Specifically, Enrollees must:
- D.2.10.1 Receive a Health Risk Assessment upon enrollment in a plan and to participate in the development and implementation of an ICP. The assessment must include considerations of social, functional, medical, behavioral, wellness and prevention domains, an evaluation of the Enrollee's strengths and weaknesses, and a plan for managing and coordination Enrollee's care. Enrollees, or their designated representative, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.
  - D.2.10.2 Receive complete and accurate information on his or her health and Functional Status by the interdisciplinary team.
  - D.2.10.3 Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in to consideration Enrollee's condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:
    - D.2.10.3.1 Before enrollment.
    - D.2.10.3.2 At enrollment.
    - D.2.10.3.3 At the time a participant's needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice.
  - D.2.10.4 Be encouraged to involve caregivers or family members in treatment discussions and decisions.
  - D.2.10.5 Have advance directives explained and to establish them, if the participant so desires, in accordance with 42 C.F.R. §§489.100 and 489.102.
  - D.2.10.6 Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer.

- D.2.10.7 Be afforded the opportunity file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review.
- D.2.10.8 The right to receive medical and non-medical care from a team that meets the Enrollee's needs, in a manner that is sensitive to the Enrollee's language and culture, and in an appropriate care setting, including the home and community.
- D.2.10.9 The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, a perceived safety measure, or retaliation.
- D.2.10.10 Each Enrollee is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the CICO and its providers or the State Agency treat the Enrollee.
- D.2.10.11 The right to receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and , the right to receive notice of any significant change in the information provided in the Orientation materials at least 30 calendar days prior to the intended effective date of the change. See 438.10 for G and H.
- D.2.10.12 The right to be protected from liability for payment of any fees that are the obligation of the CICO.
- D.2.10.13 The right not to be charged any cost sharing for Medicare Parts A and B services.

## **APPENDIX E. Relationship With First Tier, Downstream, And Related Entities**

- E.1 CICO shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on CICO's behalf related to the operation of the Medicare-Medicaid Plan are in compliance with 42 C.F.R. §§422.504, 423.505, 438.6(l), and 438.230(b)(1).
- E.2 CICO shall specifically ensure:
  - E.2.1 HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect and books, contracts, computer or other electronic systems, including medical records and documentation of the First Tier, Downstream and Related Entities; and
  - E.2.2 HHS's, the Comptroller General's, or their designees right to inspect, evaluate, and audit any pertinent information for any particular contract period for ten years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- E.3 CICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities contain the following:
  - E.3.1 Enrollee protections that include prohibiting providers from holding an Enrollee liable for payment of any fees that are the obligation of the CICO;
  - E.3.2 Language that any services or other activity performed by a First Tier, Downstream and Related Entities is in accordance with the CICO's contractual obligations to CMS and SCDHHS;
  - E.3.3 Language that specifies the delegated activities and reporting requirements;
  - E.3.4 Language that provides for revocation of the delegation activities and reporting requirements or specifies other remedies in instances where CMS, SCDHHS or the CICO determine that such parties have not performed satisfactorily;
  - E.3.5 Language that specifies the performance of the parties is monitored by the CICO on an ongoing basis, and the CICO may impose corrective action as necessary;
  - E.3.6 Language that specifies the First Tier, Downstream and Related Entities agree to safeguard Enrollee privacy and confidentiality of Enrollee health records; and
  - E.3.7 Language that specifies the First Tier, Downstream and Related Entities must comply with all Federal and State laws, regulations and CMS instructions.

- E.4 CICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that are for credentialing of medical Providers contains the following language:
- E.4.1 The credentials of medical professionals affiliated with the party or parties will be either reviewed by the CICO; or
  - E.4.2 The credentialing process will be reviewed and approved by the CICO and the CICO must audit the credentialing process on an ongoing basis.
- E.5 CICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities that delegate the selection of Providers must include language that the CICO retains the right to approve, suspend, or terminate any such arrangement.
- E.6 CICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall require the Provider to provide at least sixty (60) calendar days' notice to the CICO and assist with transitioning Enrollees to new providers, including sharing the Enrollee's medical record and other relevant Enrollee information as directed by the CICO or Enrollee.
- E.7 CICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities shall state that the CICO shall provide a written statement to a Provider of the reason or reasons for termination with cause.
- E.8 CICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for medical Providers include additional provisions. Such contracts or arrangements must contain the following:
- E.8.1 Language that the CICO is obligated to pay contracted medical Providers under the terms of the contract between the CICO and the medical Provider. The contract must contain a prompt payment provision, the terms of which are developed and agreed to by both the CICO and the relevant medical Provider;
  - E.8.2 Language that services are provided in a culturally competent manner to all Enrollees, including those with limited English proficiency or reading skills, and diverse culturally and ethnic backgrounds;
  - E.8.3 Language that medical Providers abide by all Federal and State laws and regulations regarding confidentiality and disclosure of medical records, or other health and enrollment information;
  - E.8.4 Language that medical Providers ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas;
  - E.8.5 Language that medical Providers maintain Enrollee medical records and information in an accurate and timely manner;



- E.8.6 Language that medical Providers ensure timely access by Enrollees to the records and information that pertain to them; and
- E.8.7 Language that Enrollees will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Enrollees, and that Providers shall not bill patients for charges for Covered Services other than pharmacy co-payments, if applicable.
- E.8.8 Language that clearly state the medical Providers EMTALA obligations and must not create any conflicts with hospital actions required to comply with EMTALA.
- E.8.9 Language prohibiting Providers, including, but not limited to, PCPs, from closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured Enrollees.
- E.8.10 Language that prohibits the CICO from refusing to contract or pay an otherwise eligible health care Provider for the provision of Covered Services solely because such provider has in good faith:
  - E.8.10.1 Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the CICO's health benefit plans as they relate to the needs of such Provider's patients; or
  - E.8.10.2 Communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the CICO for services provided to the patient.
- E.8.11 Language that states the Provider is not required to indemnify the CICO for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the CICO based on the CICO's management decisions, utilization review provisions or other policies, guidelines or actions.
- E.8.12 Language that states the CICO shall require Providers to comply with the CICO's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.
- E.8.13 Language that states the CICO shall notify Providers in writing of modifications in payments, modifications in Covered Services or modifications in the CICO's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the Providers, and the

effective date of the modifications. The notice shall be provided thirty (30) calendar days before the effective date of such modification unless such other date for notice is mutually agreed upon between the CICO and the provider or unless such change is mandated by CMS or SCDHHS without thirty (30) calendar days prior notice.

- E.8.14 Language that states that no payment shall be made by the CICO to a Provider for a Provider Preventable Condition; and
- E.9 CICO shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical Providers do not include incentive plans that include a specific payment to a provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services and;
  - E.9.1 The Provider shall not profit from provision of Covered Services that are not Medically Necessary or medically appropriate.
  - E.9.2 The CICO shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.
  - E.9.3 Nothing in this section shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with paragraph E.10, below.
- E.10 The CICO shall ensure that contracts or arrangements with First Tier, Downstream and Related Entities for medical Providers includes language that prohibits the CICO from imposing a financial risk on medical Providers for the costs of medical care, services or equipment provided or authorized by another Physician or health care Provider such contract includes specific provisions with respect to the following:
  - E.10.1 Stop-loss protection;
  - E.10.2 Minimum patient population size for the Physician or Physician group; and
  - E.10.3 Identification of the health care services for which the Physician or Physician group is at risk.
- E.11 The CICO shall ensure that all contracts or arrangements with First Tier, Downstream and Related Entities for laboratory testing sites providing services include an additional provision that such laboratory testing sites must have either a Clinical Laboratory Improvement Amendment (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

E.12 Nothing in this section shall be construed to restrict or limit the rights of the CICO to include as Providers religious non-medical Providers or to utilize medically based eligibility standards or criteria in deciding Provider status for religious non-medical Providers.

**APPENDIX F. Part D Addendum**

**ADDENDUM TO CAPITATED FINANCIAL ALIGNMENT CONTRACT PURSUANT TO SECTIONS 1860D-1 THROUGH 1860D-43 OF THE SOCIAL SECURITY ACT FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN**

The Centers for Medicare & Medicaid Services (hereinafter referred to as “CMS”), South Carolina, acting by and through the Department of Health and Human Services (SCDHHS), and <Entity>, a Medicare-Medicaid managed care organization (hereinafter referred to as the CICO) agree to amend the contract <Contract ID> governing the CICO’s operation of a Medicare-Medicaid Plan described in § 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as “the Act”) to include this addendum under which the CICO shall operate a Voluntary Medicare Prescription Drug Plan pursuant to §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act.

**ARTICLE I**  
**VOLUNTARY MEDICARE PRESCRIPTION DRUG PLAN**

- A. CICO agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials submitted to CMS for Medicare approval, including, but not limited to, all the attestations contained therein and all supplemental guidance, and in compliance with the provisions of this addendum, which incorporates in its entirety the *2013 Capitated Financial Alignment Application*, released on March 29, 2012 (hereinafter collectively referred to as “the addendum”). CICO also agrees to operate in accordance with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this contract and any regulations or policies implementing or interpreting such statutory or regulatory provisions.
- B. CMS agrees to perform its obligations to CICO consistent with the regulations at 42 C.F.R. Part 423 (with the exception of Subparts Q, R, and S), §§1860D-1 through 1860D-43 (with the exception of §§1860D-22(a) and 1860D-31) of the Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.
- C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 C.F.R. Part 423 that impose new, significant regulatory requirements on CICO. This provision does not apply to new requirements mandated by statute.
- D. This addendum is in no way intended to supersede or modify 42 C.F.R., Parts 417, 422, 423, 431 or 438. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to CICO, SCDHHS, and CMS.

**ARTICLE II**  
**FUNCTIONS TO BE PERFORMED BY CICO**

**A. ENROLLMENT**

CICO agrees to enroll in its Medicare-Medicaid plan only Eligible Beneficiaries as they are defined in 42 C.F.R. §423.30(a) and who have met the South Carolina Demonstration requirements and have elected to or have been passively enrolled in CICO’s Capitated Financial Alignment benefit.

**A. PRESCRIPTION DRUG BENEFIT**

1. CICO agrees to provide the required prescription drug coverage as defined under 42 C.F.R. §423.100 and, to the extent applicable, supplemental benefits as defined in 42 C.F.R. §423.100 and in accordance with Subpart C of 42 C.F.R. Part 423. CICO also

agrees to provide Part D benefits as described in CICO's Part D plan benefit package(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).

2. CICO agrees to maintain administrative and management capabilities sufficient for the organization to organize, implement, and control the financial, marketing, benefit administration, and quality assurance activities related to the delivery of Part D services as required by 42 C.F.R. §423.505(b)(25).

#### B. DISSEMINATION OF PLAN INFORMATION

1. CICO agrees to provide the information required in 42 C.F.R. §423.48.
2. CICO acknowledges that CMS releases to the public summary reconciled Part D Payment data after the reconciliation of Part D Payments for the contract year as provided in 42 C.F.R. §423.505(o).
3. CICO certifies that all materials it submits to CMS under the File and Use Certification authority described in the Medicare Marketing Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

#### C. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

1. CICO agrees to operate quality assurance, drug UM, and medication therapy management programs, and to support electronic prescribing in accordance with Subpart D of 42 C.F.R. Part 423.
2. CICO agrees to address complaints received by CMS against the CICO as required in 42 C.F.R. §423.505(b)(22) by:
  - (a) Addressing and resolving complaints in the CMS complaint tracking system; and
  - (b) Displaying a link to the electronic complaint form on the Medicare.gov Internet Web site on the Part D plan's main Web page.

#### D. APPEALS AND GRIEVANCES

CICO agrees to comply with all requirements in Subpart M of 42 C.F.R. Part 423 governing coverage determinations, Grievances and Appeals, and formulary exceptions and the relevant provisions of Subpart U governing reopenings. CICO acknowledges that these requirements are separate and distinct from the Appeals and Grievances requirements applicable to CICO through the operation of its Medicare Parts A and B and Medicaid benefits.

#### E. PAYMENT TO CICO

CICO and CMS and SCDHHS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 C.F.R. Part 423.

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## F. PLAN BENEFIT SUBMISSION AND REVIEW

If CICO intends to participate in the Part D program for the next program year, CICO agrees to submit the next year's Part D plan benefit package including all required information on benefits and cost-sharing, by the applicable due date, as provided in Subpart F of 42 C.F.R. Part 423 so that CMS, SCDHHS and CICO may conduct negotiations regarding the terms and conditions of the proposed benefit plan renewal. CICO acknowledges that failure to submit a timely plan benefit package under this section may affect the CICO's ability to offer a plan, pursuant to the provisions of 42 C.F.R. §422.4(c).

## G. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. CICO agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 C.F.R. Part 423.
2. CICO agrees to comply with Medicare Secondary Payer procedures as stated in 42 C.F.R. §423.462.

## H. SERVICE AREA AND PHARMACY ACCESS

1. CICO agrees to provide Part D benefits in the Service Area for which it has been approved by CMS and SCDHHS (as defined in Appendix J) to offer Medicare Parts A and B benefits and Medicaid benefits utilizing a pharmacy network and formulary approved by CMS and SCDHHS that meet the requirements of 42 C.F.R. §423.120.
2. CICO agrees to provide Part D benefits through out-of-network pharmacies according to 42 C.F.R. §423.124.
3. CICO agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 C.F.R. §423.100), and long-term care pharmacies (as defined in 42 C.F.R. §423.100) according to 42 C.F.R. §423.505(b)(17).
4. CICO agrees to contract with any pharmacy that meets CICO's reasonable and relevant standard terms and conditions according to 42 C.F.R. §423.505(b)(18).

## I. EFFECTIVE COMPLIANCE PROGRAM/PROGRAM INTEGRITY

CICO agrees that it will develop and implement an effective compliance program that applies to its Part D-related operations, consistent with 42 C.F.R. §423.504(b)(4)(vi).

## J. LOW-INCOME SUBSIDY

CICO agrees that it will participate in the administration of subsidies for low-income subsidy eligible individuals according to Subpart P of 42 C.F.R. Part 423.

**K. Enrollee Financial Protections**

CICO agrees to afford its Enrollees protection from liability for payment of fees that are the obligation of CICO in accordance with 42 C.F.R. §423.505(g).

**L. Relationship with first tier, downstream, and related Entities**

1. CICO agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.
2. CICO shall ensure that any contracts or agreements with First Tier, Downstream and Related Entities performing functions on CICO's behalf related to the operation of the Part D benefit are in compliance with 42 C.F.R. §423.505(i).

**M. Certification of Data That Determine Payment**

1. CICO must provide certifications in accordance with 42 C.F.R. §423.505(k).

**N. CICO REIMBURSEMENT TO PHARMACIES**

1. If CICO uses a standard for reimbursement of pharmacies based on the cost of a drug, CICO will update such standard not less frequently than once every 7 days, beginning with an initial update on January 1 of each year, to accurately reflect the market price of the drug.
2. CICO will issue, mail, or otherwise transmit payment with respect to all claims submitted by pharmacies (other than pharmacies that dispense drugs by mail order only, or are located in, or contract with, a long term care facility) within 14 days of receipt of an electronically submitted claim or within 30 days of receipt of a claim submitted otherwise.
3. CICO must ensure that a pharmacy located in, or having a contract with, a long term care facility will have not less than 30 days (but not more than 90 days) to submit claims to CICO for reimbursement.

**ARTICLE III**

**RECORD RETENTION AND REPORTING REQUIREMENTS**

**A. Record Maintenance and access**

CICO agrees to maintain records and provide access in accordance with 42 C.F.R. §§ 423.505 (b)(10) and 423.505(i)(2).

**B. GENERAL REPORTING REQUIREMENTS**

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CICO agrees to submit information to CMS according to 42 C.F.R. §§423.505(f) and 423.514, and the “Final Medicare Part D Reporting Requirements,” a document issued by CMS and subject to modification each program year.

C. CMS and South Carolina License For Use of CICO Formulary

CICO agrees to submit to CMS and SCDHHS the CICO's formulary information, including any changes to its formularies, and hereby grants to the Government, and any person or entity who might receive the formulary from the Government, a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

**ARTICLE IV  
HIPAA PROVISIONS**

- A. CICO agrees to comply with the confidentiality and Enrollee medical record accuracy requirements specified in 42 C.F.R. §423.136.
- B. CICO agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries' true out-of-pocket costs.

**ARTICLE V  
ADDENDUM TERM AND RENEWAL**

A. Term of ADDENDUM

- 1. This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2014. This addendum shall be renewable for successive one-year periods thereafter according to 42 C.F.R. §423.506.

B. Qualification to renew ADDENDUM

- 1. In accordance with 42 C.F.R. §423.507, CICO will be determined qualified to renew this addendum annually only if—
  - (a) CICO has not provided CMS or SCDHHS with a notice of intention not to renew in accordance with Article VII of this addendum, and
  - (b) CMS or SCDHHS has not provided CICO with a notice of intention not to renew.
- 2. Although CICO may be determined qualified to renew its addendum under this Article, if CICO, CMS, and SCDHHS cannot reach agreement on the Part D plan benefit package under Subpart F of 42 C.F.R. Part 423, no renewal takes place, and the failure to reach

agreement is not subject to the appeals provisions in Subpart N of 42 C.F.R. Parts 422 or 423. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

**ARTICLE VI  
NONRENEWAL OF ADDENDUM**

A. Nonrenewal by CICO

CICO may non-renew this addendum in accordance with 42 C.F.R. 423.507(a).

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 C.F.R. 423.507(b). (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

**ARTICLE VII  
MODIFICATION OR TERMINATION OF ADDENDUM BY MUTUAL CONSENT**

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 C.F.R. 423.508. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

**ARTICLE VIII  
TERMINATION OF ADDENDUM BY CMS**

CMS may terminate this addendum in accordance with 42 C.F.R. 423.509. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

**ARTICLE IX  
TERMINATION OF ADDENDUM BY CICO**

- A. CICO may terminate this addendum only in accordance with 42 C.F.R. 423.510.
- B. If the addendum is terminated under Section A of this Article, CICO must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Capitated Financial Alignment contract.)

**ARTICLE X**

**RELATIONSHIP BETWEEN ADDENDUM AND CAPITATED FINANCIAL  
ALIGNMENT CONTRACT**

- A. CICO acknowledges that, if it is a Capitated Financial Alignment CICO, the termination or nonrenewal of this addendum by any party may require CMS to terminate or non-renew the CICO's Capitated Financial Alignment contract in the event that such non-renewal or termination prevents CICO from meeting the requirements of 42 C.F.R. §422.4(c), in which case the CICO must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 C.F.R. Part 422.
- B. The termination of this addendum by any party shall not, by itself, relieve the parties from their obligations under the Capitated Financial Alignment contract to which this document is an addendum.
- C. In the event that the CICO's Capitated Financial Alignment contract is terminated or nonrenewed by any party, the provisions of this addendum shall also terminate. In such an event, CICO, SCDHHS and CMS shall provide notice to Enrollees and the public as described in this contract as well as 42 C.F.R. Part 422, Subpart K or 42 C.F.R. Part 417, Subpart K, as applicable.

**ARTICLE XI  
INTERMEDIATE SANCTIONS**

Consistent with Subpart O of 42 C.F.R. Part 423, CICO shall be subject to sanctions and civil money penalties.

**ARTICLE XII  
SEVERABILITY**

Severability of the addendum shall be in accordance with 42 C.F.R. §423.504(e).

**ARTICLE XIII  
MISCELLANEOUS**

**A. DEFINITIONS**

Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 C.F.R. Part 423 or, as applicable, 42 C.F.R. Parts 417, 422, 431 or Part 438.

**B. ALTERATION TO ORIGINAL ADDENDUM TERMS**

CICO agrees that it has not altered in any way the terms of the CICO addendum presented for signature by CMS. CICO agrees that any alterations to the original text CICO may make to this addendum shall not be binding on the parties.

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### C. ADDITIONAL CONTRACT TERMS

CICO agrees to include in this addendum other terms and conditions in accordance with 42 C.F.R. §423.505(j).

### D. CMS AND SCDHHS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES

CICO agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS and SCDHHS' approval to begin CICO marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS and SCDHHS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on CICO's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, CICO must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to send and receive transactions to and from CMS, and 4) check and receive transaction status information.

- E. Pursuant to §13112 of the American Recovery and Reinvestment Act of 2009 (ARRA), CICO agrees that as it implements, acquires, or upgrades its health information technology systems, it shall utilize, where available, health information technology systems and products that meet standards and implementation specifications adopted under § 3004 of the Public Health Service Act, as amended by §13101 of the ARRA.
- F. CICO agrees to maintain a fiscally sound operation by at least maintaining a positive net worth (total assets exceed total liabilities) as required in 42 C.F.R. §423.505(b)(23).

## **APPENDIX G. Data Use Attestation**

The CICO shall restrict its use and disclosure of Medicare and Medicaid data obtained from CMS and SCDHHS information systems (listed in Attachment A) to those purposes directly related to the administration of the Medicare/Medicaid managed care and/or outpatient prescription drug benefits for which it has contracted with the CMS and SCDHHS to administer. The CICO shall only maintain data obtained from CMS and SCDHHS information systems that are needed to administer the Medicare/Medicaid managed care and/or outpatient prescription drug benefits that it has contracted with CMS and SCDHHS to administer. The CICO (or its First Tier, Downstream or other Related Entities) may not re-use or provide other entities access to the CMS information system, or data obtained from the system or SCDHHS, to support any line of business other than the Medicare/Medicaid managed care and/or outpatient prescription drug benefit for which the CICO contracted with CMS and SCDHHS.

The CICO further attests that it shall limit the use of information it obtains from its Enrollees to those purposes directly related to the administration of such plan. The CICO acknowledges two exceptions to this limitation. First, the CICO may provide its Enrollees information about non-health related services after obtaining consent from the Enrollees. Second, the CICO may provide information about health-related services without obtaining prior Enrollee consent, as long as the CICO affords the Enrollee an opportunity to elect not to receive such information.

CMS may terminate the CICO's access to the CMS data systems immediately upon determining that the CICO has used its access to a data system, data obtained from such systems, or data supplied by its Enrollees beyond the scope for which CMS and the SCDHHS have authorized under this agreement. A termination of this data use agreement may result in CMS or SCDHHS terminating the CICO's Medicare-Medicaid contract(s) on the basis that it is no longer qualified as a CICO. This agreement shall remain in effect as long as the CICO remains a CICO sponsor. This agreement excludes any public use files or other publicly available reports or files that CMS or SCDHHS make available to the general public on their websites.

### Attachment A

The following list contains a representative (but not comprehensive) list of CMS information systems to which the Data Use Attestation applies. CMS will update the list periodically as necessary to reflect changes in the agency's information systems

- Automated Plan Payment System (APPS)
- Common Medicare Environment (CME)
- Common Working File (CWF)
- Coordination of Benefits Contractor (COBC)
- Drug Data Processing System (DDPS)
- Electronic Correspondence Referral System (ECRS)
- Enrollment Database (EDB)
- Financial Accounting and Control System (FACS)
- Front End Risk Adjustment System (FERAS)

- Health Plan Management System (HPMS), including Complaints Tracking and all other modules
- HI Master Record (HIMR)
- Individuals Authorized Access to CMS Computer Services (IACS)
- Integrated User Interface (IUI)
- Medicare Advantage Prescription Drug System (MARx)
- Medicare Appeals System (MAS)
- Medicare Beneficiary Database (MBD)
- Payment Reconciliation System (PRS)
- Premium Withholding System (PWS)
- Prescription Drug Event Front End System (PDFS)
- Retiree Drug System (RDS)
- Risk Adjustments Processing Systems (RAPS)

Where applicable, Medicaid systems include:

- Cúram
- Phoenix Automatic Case Management System
- Medicaid Management Information System (MMIS – Legacy and Replacement)
- Oracle B2B (Business-to-Business)

## **APPENDIX H. Model File & Use Certification Form**

Pursuant to the contract between the Centers for Medicare & Medicaid Services (CMS), the State of South Carolina, acting by and through Department of Health and Human Services (SCDHHS), and <Entity>, hereafter referred to as the CICO, governing the operations of the following health plan: <insert health plan marketing name> (<Contract ID>), the CICO hereby certifies that all qualified materials for the Demonstration is accurate, truthful and not misleading. Organizations using File & Use Certification agree to retract and revise any materials (without cost to the government) that are determined by CMS or SCDHHS to be misleading or inaccurate or that do not follow established Medicare Marketing Guidelines, Regulations, and sub-regulatory guidance. In addition, organizations may be held accountable for any beneficiary financial loss as a result of mistakes in marketing materials or for misleading information that results in uninformed decision by a beneficiary to elect the plan. Compliance criteria include, without limitation, the requirements in 42 C.F.R. § 422.2260 – §422.2276 and 42 C.F.R. § 422.111 for CICOs and the Medicare Marketing Guidelines.

I agree that CMS or SCDHHS may inspect any and all information including those held at the premises of the CICO to ensure compliance with these requirements. I further agree to notify CMS and SCDHHS immediately if I become aware of any circumstances that indicate noncompliance with the requirements described above.

**APPENDIX I. Medicare Mark License Agreement**

THIS AGREEMENT is made and entered into on September 5, 2014

by and between

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (hereinafter “Licensor”),

with offices located at 7500 Security Blvd., Baltimore, MD 21244

and

<Entity> (hereinafter “Licensee”),

with offices located at

<Address>

**CMS Contract ID: <CONTRACT ID>**



## WITNESSETH

**WHEREAS**, Licensor is the owner of the Medicare Prescription Drug Benefit program, a program authorized under Title XVIII, Part D of the Social Security Act (Part D), Mark (the "Mark").

**WHEREAS**, Licensee desires to use the Mark on Part D marketing materials (including the identification card) beginning September 5, 2014.

**WHEREAS**, both parties, in consideration of the premises and promises contained herein and other good and valuable consideration which the parties agree is sufficient, and each intending to be legally bound thereby, the parties agree as follows:

1. Subject to the terms and conditions of this Agreement, Licensor hereby grants to Licensee a non-exclusive right to use the Mark in their Part D marketing materials.
2. Licensee acknowledges Licensor's exclusive right, title, and interest in and to the Mark and will not, at any time, do or cause to be done any act or thing contesting or in any way impairing or tending to impair any part of such right, title, and interest. Licensee acknowledges that the sole right granted under this Agreement with respect to the Mark is for the purposes described herein, and for no other purpose whatsoever.
3. Licensor retains the right to use the Mark in the manner or style it has done so prior to this Agreement and in any other lawful manner.
4. This Agreement and any rights hereunder are not assignable by Licensee and any attempt at assignment by Licensee shall be null and void.
5. Licensor, or its authorized representative, has the right, at all reasonable times, to inspect any material on which the Mark is to be used, in order that Licensor may satisfy itself that the material on which the Mark appears meets with the standards, specifications, and instructions submitted or approved by Licensor. Licensee shall use the Mark without modification and in accordance with the Mark usage policies described within the Medicare Marketing Guidelines. Licensee shall not take any action inconsistent with the Licensor's ownership of the Mark, and any goodwill accruing from use of such Mark shall automatically vest in Licensor.
6. This agreement shall be effective on the date of signature by the Licensee's authorized representative through December 31, 2014, concurrent with the execution of the Part D addendum to the three way contract. This Agreement may be terminated by either party upon written notice at any time. Licensee agrees, upon written notice from Licensor, to discontinue any use of the Mark immediately. Starting December 31, 2013, this agreement shall be renewable for successive one-year periods running concurrently with the term of the Licensee's Part D contract. This agreement shall terminate, without written notice, upon the effective date of termination or non-renewal of the Licensee's

Part D contract (or Part D addendum to a Capitated Financial Alignment Demonstration contract).

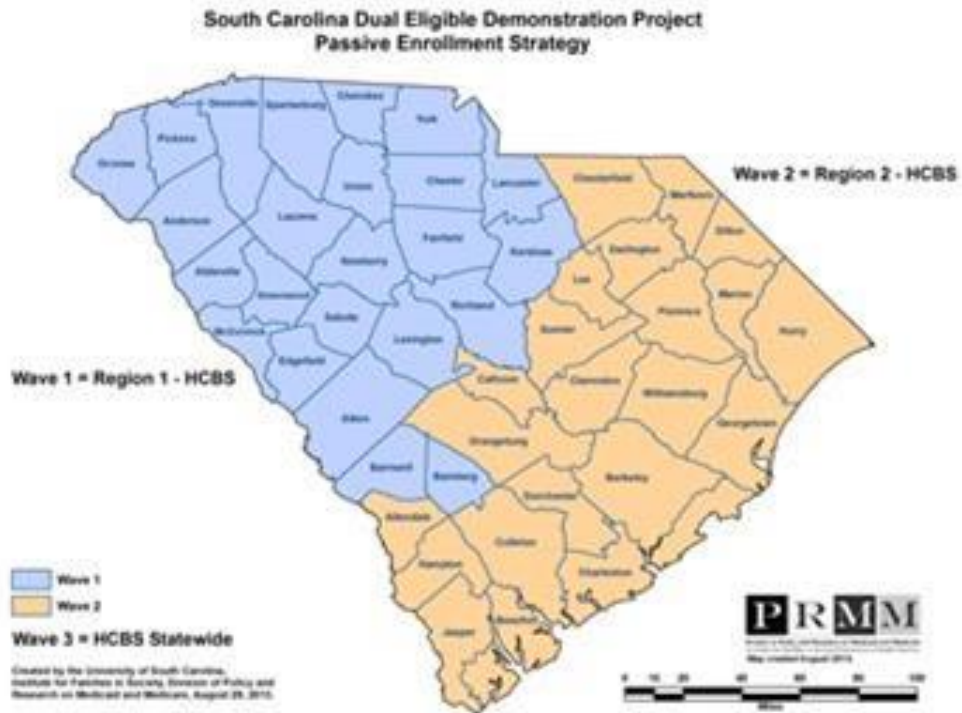
7. Licensee shall indemnify, defend and hold harmless Licensor from and against all liability, demands, claims, suits, losses, damages, infringement of proprietary rights, causes of action, fines, or judgments (including costs, attorneys' and witnesses' fees, and expenses incident thereto), arising out of Licensee's use of the Mark.
8. Licensor will not be liable to Licensee for indirect, special, punitive, or consequential damages (or any loss of revenue, profits, or data) arising in connection with this Agreement even if Licensor has been advised of the possibility of such damages.
9. This Agreement is the entire agreement between the parties with respect to the subject matter hereto.
10. Federal law shall govern this Agreement.

## APPENDIX J. Service Area

The Service Area outlined below is contingent upon the Contactor meeting all Readiness Review requirements in each county. CMS and SCDHHS reserve the right to amend this Appendix to revise the Service Area based on final Readiness Review results or subsequent determinations made by CMS and SCDHHS. The Service Area consists of the following Counties:

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

## Exhibit 5 Geographic Regions



**APPENDIX K. Assessment and Individualized Care Plan Expectations**

**Exhibit 6 Assessment and ICP Requirements**

Population	Criteria	Initial Health Screen	Comprehensive Assessment	Long Term Care Level of Care Assessment	Individualized Care Plan- Initial	Continuous monitoring and Review	Waiver Service Plan	Face-to-Face reassessment	Individualized Care Plan – Update
Low Risk	Determined by CICO during initial Health Risk Screen	Within 30 days of enrollment  CICOs may forego the initial health screen when completing the comprehensive assessment within 60 days of enrollment.	Within 90 days of enrollment	Necessary only if CICO believes an Enrollee may need LTC services or if requested by an Enrollee/ authorized representative	Within 90 days of enrollment	Every 120 days	Not Applicable	At least every three-hundred and sixty-five days, or when there is a change in the Enrollee’s health status or needs, a significant health care event, or as requested by the Enrollee, his/her caregiver or his/her provider	Any time a face-to-face reassessment occurs
Moderate Risk	Determined by CICO during Health Risk Screen		Within 60 days of enrollment	Necessary only if CICO believes an Enrollee may need LTC services or if requested by an Enrollee/ authorized representative	Within 90 days of enrollment	Every 90 days	Not Applicable		
High Risk : Waiver and NF Enrollees	SCDHHS HCBS waiver Enrollees or NF residents		Within 60 days of enrollment	Not Required	Within 90 days of enrollment	Every 30 days	For waiver Enrollees only: developed by SCDHHS with CICO concurrence in Phase I; developed by CICO with SCDHHS concurrence in Phase II and after		
High Risk: All Other	Determined by CICO during Health Risk Screen		Within 60 days of enrollment	Required, conducted by SCDHHS concurrently with comprehensive assessment	Within 90 days of enrollment	Every 30 days	Not Applicable		

**APPENDIX L. Revised Core Quality Measures under the Demonstration**

The table below is a revised version of Figure 7-4 of the MOU between CMS and the State of South Carolina on October 25, 2013 and reflects further refinements made to the South Carolina specific measures. Note that all CMS core requirements remain the same.

**Exhibit 7 Revised Core Quality Measures under the Demonstration**

<b>Measure</b>	<b>Description</b>	<b>Measure Steward/Data Source</b>	<b>CMS Core Measure</b>	<b>State Measure</b>
Antidepressant medication management	Percentage of members who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	NCQA/HEDIS	X	
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	The percentage of members with a new episode of alcohol or other drug (AOD) dependence who received the following: <ul style="list-style-type: none"> <li>• Initiation of AOD Treatment. The percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.</li> <li>• Engagement of AOD Treatment. The percentage of members who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.</li> </ul>	NCQA/HEDIS	X	
Follow-up After Hospitalization for Mental Illness	Percentage of discharges who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner	NCQA/HEDIS	X	
Screening for Clinical Depression and Follow-up Care	Percentage of patients screened for clinical depression using a standardized tool and follow-up plan documented.	CMS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
SNP1: Complex Case Management	<p>The organization coordinates services for members with complex conditions and helps them access needed resources.</p> <p>Element A: Identifying Members for Case Management            Element B: Access to Case Management            Element C: Case Management Systems            Element D: Frequency of Member Identification            Element E: Providing Members with Information            Element F: Case Management Assessment Process            Element G: Individualized Care Plan            Element H: Informing and Educating Practitioners            Element I: Satisfaction with Case Management            Element J: Analyzing Effectiveness/Identifying Opportunities            Element K: Implementing Interventions and Follow-up Evaluation</p>	NCQA/ SNP Structure & Process Measures	X	
SNP 6: Coordination of Medicare and Medicaid Benefits	<p>The organization coordinates Medicare and Medicaid benefits and services for members.</p> <p>Element A: Coordination of Benefits for Dual Eligible Members            Element B: Administrative Coordination of D-SNPs            Element C: Administrative Coordination for Chronic Condition and Institutional Benefit Packages (May not be applicable for demos)            Element D: Service Coordination Element E: Network Adequacy Assessment</p>	NCQA/ SNP Structure & Process Measures HEDIS	X	
Care Transition Record Transmitted to Health Care Professional	<p>Percentage of patients, regardless of age, discharged from an inpatient facility to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.</p>	AMA-PCPI	X	
Medication Reconciliation After Discharge from Inpatient Facility	<p>Percent of patients 65 years or older discharged from any inpatient facility and seen within 60 days following discharge by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.</p>	NCQA/HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
SNP 4: Care Transitions	<p>The organization manages the process of care transitions, identifies problems that could cause transitions and where possible prevents unplanned transitions.</p> <p>Element A: Managing Transitions            Element B: Supporting Members through Transitions            Element C: Analyzing Performance            Element D: Identifying Unplanned Transitions            Element E; Analyzing Transitions            Element F: Reducing Transitions</p>	NCQA/ SNP Structure & Process Measures HEDIS	X	
CAHPS, various settings including: -Health Plan plus supplemental items/questions, including: -Experience of Care and Health Outcomes for Behavioral Health (ECHO) -Home Health -Nursing Home -People with Mobility Impairments -Cultural Competence -Patient Centered Medical Home	Depends on Survey.	AHRQ/CAHPS	X	
Part D Call Center – Pharmacy Hold Time	How long pharmacists wait on hold when they call the drug plan’s pharmacy help desk.	CMS Call Center data	X	
Part D Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that TTY/TDD services and foreign language interpretation were available when needed by members who called the drug plan’s customer service phone number.	CMS Call Center data	X	



Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Part D Appeals Auto– Forward	<p>How often the drug plan did not meet Medicare’s deadlines for timely appeals decisions.</p> <p>This measure is defined as the rate of cases auto-forwarded to the Independent Review Entity (IRE) because decision timeframes for coverage determinations or redeterminations were exceeded by the plan. This is calculated as: [(Total number of cases auto-forwarded to the IRE) / (Average Medicare Part D enrollment)] * 10,000.</p>	IRE	X	
Part D Appeals Upheld	<p>How often an independent reviewer agrees with the drug plan's decision to deny or say no to a member’s appeal.</p> <p>This measure is defined as the percent of IRE confirmations of upholding the plans’ decisions. This is calculated as: [(Number of cases upheld) / (Total number of cases reviewed)] * 100.</p>	IRE	X	
Part D Complaints about the Drug Plan	<p>How many complaints Medicare received about the drug plan.</p> <p>For each contract, this rate is calculated as: [(Total number of complaints logged into the CTM for the drug plan regarding any issues) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).</p>	CMS  CTM data	X	
Part D Beneficiary Access and Performance Problems	<p>To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare’s rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.</p>	CMS  Administrative data	X	
Part D Members Choosing to Leave the Plan	<p>The percent of drug plan members who chose to leave the plan in 2014.</p>	CMS  Medicare Beneficiary Database Suite of Systems	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Part D MPF Accuracy	The accuracy of how the Plan Finder data match the PDE data.	CMS  PDE data, MPF Pricing Files, HPMS approved formulary extracts, and data from First DataBank and Medispan	X	
Part D High Risk Medication	The percent of the drug plan members who get prescriptions for certain drugs with a high risk of serious side effects, when there may be safer drug choices.	CMS PDE data	X	
Part D Diabetes Treatment	Percentage of Medicare Part D beneficiaries who were dispensed a medication for diabetes and a medication for hypertension who were receiving an angiotensin converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) medication which are recommended for people with diabetes.	CMS  PDE data	X	
Part D Medication Adherence for Oral Diabetes Medications	Percent of plan members with a prescription for oral diabetes medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS  PDE data	X	
Part D Medication Adherence for Hypertension (ACEI or ARB)	Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS  PDE data	X	
Part D Medication Adherence for Cholesterol (Statins)	Percent of plan members with a prescription for a cholesterol medication (a statin drug) who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication.	CMS  PDE data	X	
Plan Makes Timely Decisions about Appeals	Percent of plan members who got a timely response when they made an appeal request to the health plan about a decision to refuse payment or coverage.	IRE	X	
Reviewing Appeals Decisions	How often an independent reviewer agrees with the plan's decision to deny or say no to a member's appeal.	IRE	X	
Call Center – Foreign Language Interpreter and TTY/TDD Availability	Percent of the time that the TTY/TDD services and foreign language interpretation were available when needed by members who called the health plan's customer service phone number.	CMS  Call Center data	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Percent of High Risk Residents with Pressure Ulcers (Long Stay)	Percentage of all long-stay residents in a nursing facility with an annual, quarterly, significant change or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2-4 pressure ulcer(s).	NQF endorsed	X	
Beneficiary Governance Board	Establishment of beneficiary/ consumer advisory board or inclusion of beneficiaries/ consumers on governance board consistent with contract requirements.	CMS/State defined process measure	X	
Customer Service	Percent of best possible score the plan earned on how easy it is to get information and help when needed.  <ul style="list-style-type: none"> <li>In the last 6 months, how often did your health plan's customer service give you the information or help you needed?</li> </ul> In the last 6 months, how often did your health plan's customer service treat you with courtesy and respect?  In the last 6 months, how often were the forms for your health plan easy to fill out?	AHRQ/CAHPS	X	
Assessments	Percent of Enrollees with initial assessments completed within required timeframes.	CMS/State defined process measure	X	
Individualized care plans	Percent of members with care plans by specified timeframe.	CMS/State defined process measure	X	
Real time hospital admission notifications	Percent of hospital admission notifications occurring within specified timeframe.	CMS/State defined process measure	X	
Risk stratification based on LTSS or other factors	Percent of risk stratifications using BH/LTSS data/indicators.	CMS/State defined process measure	X	
Discharge follow-up	Percent of members with specified timeframe between hospital discharge to first follow-up visit.	CMS/State defined process measure	X	
Self-direction	Percent of care coordinators that have undergone State-based training for supporting self-direction under the Demonstration.	CMS/State defined process measure	X	
Care for Older Adults – Medication Review	Percent of plan members whose doctor or clinical pharmacist has reviewed a list of everything they take (prescription and non-prescription drugs, vitamins, herbal remedies, other supplements) at least once a year.	NCQA/ HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Care for Older Adults – Functional Status Assessment	Percent of plan members whose doctor has done a —functional status assessment to see how well they are doing —activities of daily living (such as dressing, eating, and bathing).	NCQA/HEDIS	X	
Care for Older Adults – Pain Screening	Percent of plan members who had a pain screening or pain management plan at least once during the year.	NCQA/HEDIS	X	
Diabetes Care – Eye Exam	Percent of plan members with diabetes who had an eye exam to check for damage from diabetes during the year.	NCQA/HEDIS	X	
Diabetes Care – Kidney Disease Monitoring	Percent of plan members with diabetes who had a kidney function test during the year.	NCQA/HEDIS	X	
Diabetes Care – Blood Sugar Controlled	Percent of plan members with diabetes who had an A-1-C lab test during the year that showed their average blood sugar is under control.	NCQA/HEDIS	X	
Rheumatoid Arthritis Management	Percent of plan members with Rheumatoid Arthritis who got one or more prescription(s) for an anti-rheumatic drug.	NCQA/HEDIS	X	
Reducing the Risk of Falling	Percent of members with a problem falling, walking or balancing who discussed it with their doctor and got treatment for it during the year.	NCQA/HEDIS HOS	X	
Plan All-Cause Readmissions	Percent of members discharged from a hospital stay who were readmitted to a hospital within 30 days, either from the same condition as their recent hospital stay or for a different reason.	NCQA/HEDIS	X	
Controlling Blood Pressure	Percentage of members who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year.	NCQA/HEDIS	X	
Comprehensive medication review	Percentage of beneficiaries who received a comprehensive medication review (CMR) out of those who were offered a CMR.	Pharmacy Quality Alliance (PQA) Part D Reporting Data	X	
Complaints about the Health Plan	How many complaints Medicare received about the health plan. Rate of complaints about the health plan per 1,000 members. For each contract, this rate is calculated as: [(Total number of all complaints logged into the CTM) / (Average Contract enrollment)] * 1,000 * 30 / (Number of Days in Period).	CMS CTM data	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Beneficiary Access and Performance Problems	To check on whether members are having problems getting access to care and to be sure that plans are following all of Medicare's rules, Medicare conducts audits and other types of reviews. Medicare gives the plan a lower score (from 0 to 100) when it finds problems. The score combines how severe the problems were, how many there were, and how much they affect plan members directly. A higher score is better, as it means Medicare found fewer problems.	CMS Beneficiary database	X	
Members Choosing to Leave the Plan	The percent of plan members who chose to leave the plan in plan year	CMS	X	
Getting Information From Drug Plan	<p>The percent of the best possible score that the plan earned on how easy it is for members to get information from their drug plan about prescription drug coverage and cost.</p> <p>In the last 6 months, how often did your health plan's customer service give you the information or help you needed about prescription drugs?</p> <p>In the last 6 months, how often did your plan's customer service staff treat you with courtesy and respect when you tried to get information or help about prescription drugs?</p> <p>In the last 6 months, how often did your health plan give you all the information you needed about prescription medication were covered?</p> <p>In the last 6 months, how often did your health plan give you all the information you needed about how much you would have to pay for your prescription medicine?</p>	AHRQ/CAHPS	X	
Rating of Drug Plan	<p>The percent of the best possible score that the drug plan earned from members who rated the drug plan for its coverage of prescription drugs.</p> <p>Using any number from 0 to 10, where 0 is the worst prescription drug plan possible and 10 is the best prescription drug plan possible, what number would you use to rate your health plan for coverage of prescription drugs?</p>	AHRQ/CAHPS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Getting Needed Prescription Drugs	<p>The percent of best possible score that the plan earned on how easy it is for members to get the prescription drugs they need using the plan.</p> <p>-In the last 6 months, how often was it easy to use your health plan to get the medicines your doctor prescribed?</p> <p>-In the last six months, how often was it easy to use your health plan to fill a prescription at a local pharmacy?</p>	AHRQ/CAHPS	X	
Getting Needed Care	<p>Percent of best possible score the plan earned on how easy it is to get needed care, including care from specialists.</p> <p>In the last 6 months, how often was it easy to get appointments with specialists? • In the last 6 months, how often was it easy to get the care, tests, or treatment you needed through your health plan?</p>	AHRQ/CAHPS	X	
Getting Appointments and Care Quickly	<p>Percent of best possible score the plan earned on how quickly members can get appointments and care.</p> <p>In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed? • In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?</p> <p>In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?</p>	AHRQ/CAHPS	X	
Overall Rating of Health Care Quality	<p>Percent of best possible score the plan earned from plan members who rated the overall health care received.</p> <p>Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 6 months?</p>	AHRQ/CAHPS	X	
Overall Rating of Plan	<p>Percent of best possible score the plan earned from plan members who rated the overall plan.</p> <p>Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?</p>	AHRQ/CAHPS	X	
Breast Cancer Screening	Percent of female plan members aged 40- 69 who had a mammogram during the past 2 years.	NCQA/ HEDIS	X	
Colorectal Cancer Screening	Percent of plan members aged 50-75 who had appropriate screening for colon cancer.	NCQA/HEDIS	X	

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Cardiovascular Care – Cholesterol Screening	Percent of plan members with heart disease who have had a test for —badl (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Diabetes Care – Cholesterol Screening	Percent of plan members with diabetes who have had a test for —badl (LDL) cholesterol within the past year.	NCQA/HEDIS	X	
Annual Flu Vaccine	Percent of plan members who got a vaccine (flu shot) prior to flu season.	AHRQ/CAHPS Survey data	X	
Improving or Maintaining Mental Health	Percent of all plan members whose mental health was the same or better than expected after two years.	CMS HOS	X	
Monitoring Physical Activity	Percent of senior plan members who discussed exercise with their doctor and were advised to start, increase or maintain their physical activity during the year.	HEDIS / HOS	X	
Access to Primary Care Doctor Visits	Percent of all plan members who saw their primary care doctor during the year.	HEDIS	X	
Access to Specialists	Proportion of respondents who report that it is always easy to get appointment with specialists.	AHRQ/CAHPS	X	
Getting Care Quickly	Composite of access to urgent care.	AHRQ/CAHPS	X	
Being Examined on the Examination table	Percentage of respondents who report always being examined on the examination table.	AHRQ/CAHPS	X	
Help with Transportation	Composite of getting needed help with transportation.	AHRQ/CAHPS	X	
Health Status/Function Status	Percent of members who report their health as excellent.	AHRQ/CAHPS	X	
Glaucoma screening in older adults	Percentage of Medicare members 65 years and older who received a glaucoma eye exam by an eye care professional for early identification of glaucomatous conditions.	NCQA		X
Aspirin use and discussion	Percentage of Enrollees who are currently taking aspirin, and percentage of Enrollees who discussed the risks and benefits of using aspirin with a doctor or other health provider	NCQA		X
Pneumonia Vaccine	Percentage of Enrollees aged 65 and older who have ever received a pneumonia vaccine	NCQA		X
Diabetes: Foot Exam	The percentage of patients 18-75 years of age with diabetes (type 1 and type 2) who received a foot exam (visual inspection with either a sensory exam or a pulse exam) during the measurement year.	NCQA		X

Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Management of COPD exacerbation	This measure assesses the percentage of COPD exacerbations for members 40 years of age and older who had an acute inpatient discharge or ED encounter during the measurement year and who were dispensed appropriate medications.	NCQA		X
Management of urinary incontinence	Percent of Enrollees with identified incontinence who have received treatment or documented intervention from a provider	State - Specified		X
Osteoporosis management	The percentage of women 67 years of age and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the six months after the date of fracture.	NCQA		X
Suicide risk assessment	Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified	AMA/PCI		X
Mental Health Management	Number and percentage of Enrollees receiving the following mental health services during the measurement year: any service, in-patient, intensive outpatient or partial hospitalization, and outpatient or ED.	NCQA/ HEDIS		X
Potentially harmful drug-disease interactions in the elderly	Percentage of Medicare members 65 years of age and older who have a diagnosis of dementia and a prescription for antiemetics, antipsychotics, benzodiazepines, tricyclic antidepressants, H2 receptor antagonists, nonbenzodiazepine hypnotics or anticholinergic agents	NCQA		X
Closing the referral loop: Receipt of specialist report	This CQM measures the percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	CMS		X
Cost of Care	Total cost of care PMPM	NCQA		X
Emergency department utilization	Utilization per year per a thousand enrollee	NCQA		X
Mental health services utilization	Number and percentage of Enrollees receiving the following mental health services during the measurement year: any service, in-patient, intensive outpatient or partial hospitalization, and outpatient or ED.	HEDIS		X
Adults' access to preventive/ ambulatory health services	This measure is used to assess the percentage of members 20 to 44 years, 45 to 64 years, and 65 years and older who had an ambulatory or preventive care visit.	CMS		X



Measure	Description	Measure Steward/Data Source	CMS Core Measure	State Measure
Palliative Care	Percentage of Enrollees receiving the palliative care benefit who indicate they are uncomfortable because of pain whose pain was brought to a comfortable level within 48 hours of start of service.	NCF		X
HCBS Plan of Care	Percent of enrollees eligible for HCBS with a waiver service plan with specified timeframes.	State-Specified		X
Access to Service	Number and percent of enrollees receiving HCBS like services (as part of capitation) prior to enrollee reaching level of care to be eligible for HCBS.	State - Specified		X
Percentage of residents experiencing one or more falls with major injury (long stay)	This measure is based on data from all target MDS 3.0 assessments of long-stay nursing home residents (OBRA, PPS or discharge). It reports the percentage of residents who experience one or more falls with major injury (e.g., bone fractures, joint dislocations, closed head injuries with altered consciousness, or subdural hematoma) in the last quarter (3-month period). The measure is based on MDS 3.0 item J1900C, which indicates whether any falls that occurred were associated with major injury.	MDS		X
The percentage of residents on a scheduled pain medication regimen on admission who self-report a decrease in pain intensity or frequency (short-stay)	This measure is based on data from the MDS 3.0 assessment of short stay nursing facility residents and reports the percentage of those short-stay residents who can self-report and who are on a scheduled pain medication regimen at admission (5-day PPS MDS assessment) and who report lower levels of pain on their discharge MDS 3.0 assessment or their 14-day PPS MDS assessment (whichever comes first) when compared with the 5- day PPS MDS assessment.	MDS		X
Percentage of residents with pressure ulcers that are new or worsened (short stay)	The number of residents or patients with a target assessment during the selected time window, who have one or more Stage 2-4 pressure ulcer(s) that are new or that have worsened compared with the prior assessment. Since it is difficult to objectively measure Stage 1 pressure ulcers across different populations, this category of pressure ulcers are excluded from this measure (1).	MDS		X
HCBS Consumer Satisfaction	Percent of Enrollees Receiving HCBS who are satisfied/very satisfied with these services	State-specified		X
HCBS Authorization-Consumer Directed Services	Percent of Enrollees receiving HCBS who used consumer directed services	State-specified		X
HCBS Authorization- Personal Care Hours	Percent of Enrollees receiving HCBS who experienced an increase/decrease in the authorization of personal care hours (each reported separately)	State-specified		X

<b>Measure</b>	<b>Description</b>	<b>Measure Steward/Data Source</b>	<b>CMS Core Measure</b>	<b>State Measure</b>
HCBS Authorization-Respite Care	Percent of Enrollees receiving HCBS who experienced an increase/decrease in the authorization of respite hours (each reported separately)	State-specified		X
HCBS Authorization- Non-consumer directed services	Percent of Enrollees receiving HCBS who experienced an increase/decrease in the authorization of non-consumer directed HCBS services (each reported separately)	State-specified		X
Adjudicated Claims, including HCBS Case Management	Percent of adjudicated claims submitted to CICOs that were paid within the timely filing requirements	State-specified		X
Individualized Care Plan	Proportion of enrollees at each risk level (high-, medium-, low-) with an Individualized Care Plan (ICP) developed within specified timeframes compared to total enrollees at each risk level requiring ICPs	State-specified		X
Hospital, Nursing Facility and Community Transition Planning	CICO has an established work plan and systems in place, utilizing Phoenix as appropriate, for ensuring smooth transition to and from hospitals, nursing facilities and the community.	State-specified		X
Managing Hospital, Nursing Facility and Community Transitions	<p>Percentage of enrollees who transitioned to and from hospitals, nursing facilities and the community.</p> <p>Proportion of those who transitioned to and from hospitals, nursing facilities and the community who returned to an (1) institutional setting or (2) community.</p> <p>Percentage of Care transitions recorded and transmitted to CICO Care Coordinator (via Phoenix)</p>	State-specified		X