SOUTH CAROLINA MEDICAID PROGRAM
REGULATORY REQUIREMENTS APPENDIX
DOWNSTREAM PROVIDER

THIS SOUTH CAROLINA MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between March Vision Care Group, Incorporated ("Subcontractor") and the party named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans under the State of South Carolina Medicaid Program (the "Medicaid Program" as defined in more detail below) as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "State Contract" as defined herein). The State Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit contracts outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State and requested by Health Plan, Provider agrees that Subcontractor shall be permitted to unilaterally initiate such additions, deletions or modifications.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the Medicaid Program, the definitions shall have the meaning set forth under the Medicaid Program.

2.1 **Agreement:** An executed contract between Subcontractor and Provider for the provision of Covered Services to persons enrolled in the Medicaid Program.

2.2 **Covered Person:** An individual who is currently enrolled with Health Plan for the provision of services under the Medicaid Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.3 **Covered Services:** A health care service or product for which a Covered Person is enrolled with Health Plan to receive coverage under the State Contract.

2.4 **Health Plan:** An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain administrative services on behalf of Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to Unison Health Plan of South Carolina, Inc.

2.5 **Medicaid Program**: The South Carolina medical assistance plan under Title XIX of the Social Security Act. For purposes of this Appendix, Medicaid Program may refer to the government agency responsible for administering the Medicaid Program (SCDHHS) and may also be read to include other government oversight agencies including, as applicable, the South Carolina Department of Insurance and the Centers for Medicare and Medicaid Services ("CMS").

2.6 **Provider:** A hospital, ancillary provider, primary care or specialty care individual physician or group, or other health care provider that is qualified and appropriately licensed to provide health care services to individuals enrolled in the Medicaid Program and has entered into an Agreement or is subject to and renders Covered Services under an Agreement for such services.

2.7 **SCDHHS:** The South Carolina Department of Health and Human Services**,** the State agency which administers the Medicaid Program as defined herein.

2.8 **State:** The State of South Carolina or its designated regulatory agencies.

2.9 **State Contract:** Health Plan's contract with SCDHHS for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the Medicaid Program. For purposes of this Appendix, the State Contract shall include the Managed Care Organization ("MCO") Policy and Procedure Guide published by SCDHHS, as amended from time to time.

SECTION 3
PROVIDER REQUIREMENTS

The Medicaid Program, through federal and State statutes and regulations and contractual requirements, requires the Agreement to contain certain conditions that Health Plan, Subcontractor, and Provider agree to undertake, which include the following:

3.1 Provider shall follow the State Contract's provisions for the coverage of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are as follows: (1) furnished by a provider qualified to furnish these health services under the Medicaid Program; and (2) needed to evaluate or stabilize an Emergency Medical Condition. No prior authorization is required for Emergency Services.

(c) "EPSDT Services" are specified by 42 USC §§ 1396a(a)(43), 1396d(a) and (r) and 42 CFR Part 441, Subpart B as early and periodic screening, diagnosis and treatment of Covered Persons under age 21 to identify physical and mental defects, illnesses and conditions, and provide treatment to correct or ameliorate the defects, illnesses and conditions discovered thereby, regardless whether services are Covered Services.

(d) Medically Necessary or Medical Necessity: Medical services which are (1) essential to prevent, diagnose, prevent the worsening of, alleviate, correct or cure medical conditions that endanger the 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 Covered Person; (2) provided at an appropriate facility and at the appropriate level of care for the treatment of the Covered Person's medical condition; and (3) provided in accordance with generally accepted standards of medical practice.

3.2 Provider shall provide for timely access to Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, including without limitation, appointments for preventive care, urgent care, routine sick care, and well care.

3.3 Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries.

3.4 Provider shall provide information to Covered Persons regarding treatment options, including the option of no treatment, in a culturally-competent manner and shall ensure that individuals with disabilities have effective communications in making decisions regarding treatment options, pursuant to the requirements of the State Contract or as otherwise may be required by law. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et. seq*.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Provider shall take adequate steps to ensure that Covered Persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the State Contract.

3.5 Provider may not refuse to render Medically Necessary or preventive Covered Services to Covered Persons for non-medical reasons.

3.6 Providers that are hospitals shall notify Health Plan, Subcontractor and SCDHHS of births when the mother is a Covered Person. In addition, hospital Providers are responsible for

completing SCDHHS's Request for Medicaid ID Number (Form 1716 ME), including indicating whether the mother is a member of an MCO, and submitting the form to the local or State SCDHHS office.

3.7 Providers that are primary care providers ("PCPs") shall conduct or arrange for EPSDT screens in accordance with the requirements of the Medicaid Program and the State Contract, and shall submit all reports and clinical information as required by Health Plan and Subcontractor.

3.8 Providers that are Federally Qualified Health Centers ("FQHC") or Rural Health Clinics ("RHC") that provide services to Covered Persons under the age of twenty-one (21) shall conduct all EPSDT screens for such Covered Persons on the FQHC/RHC's panel. If the FQHC/RHC is unable to conduct the necessary EPSDT screens, the FQHC/RHC shall arrange for another Provider to conduct the EPSDT screens and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Persons' medical records maintained by the FQHC/RHC. The FQHC/RHC shall submit encounter data associated with EPSDT screens within ninety (90) days of the date of service using a format approved by Health Plan for meeting SCDHHS's reporting requirements under the State Contract.

3.9 Provider shall comply with the following record retention and access requirements:

(a) Maintenance. Provider shall maintain an adequate record keeping system for recording services, service providers, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons pursuant to the Agreement, including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services rendered pursuant to the State Contract. All records originated or prepared in connection with Provider's performance of its obligations under the Agreement, including but not limited to, working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers, and electronic media, shall be retained and safeguarded by Provider in accordance with the terms and conditions of the State Contract. Provider shall maintain up-to-date medical records at the site where medical services are provided to Covered Persons. Each Covered Person's medical record must be legible and maintained in detail consistent with good medical and professional practice that permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. Provider shall allow SCDHHS representatives or designees immediate access to all records pertaining to the health care services provided to Covered Persons. Medical record requirements are further defined in the MCO Policy and Procedure Guide. Covered Persons or their representatives may access, and subject to reasonable charges, receive copies of the Covered Person's medical records, to the extent and in the manner provided by SC Code Ann. §44-115-10 *et seq.*, as amended from time to time.

(b) Retention. All financial and programmatic records, supporting documents, statistical records and other records relating to the delivery of care or services under the State Contract, and as further required by SCDHHS, shall be retained by Provider for the

later of five (5) years after the expiration of the State Contract (including any extensions thereof) or such other period as required by applicable State or federal law. If any litigation, claim, audit, review, or other action involving the records has been initiated prior to the expiration of the five (5) year period, the records shall be retained until completion of the action and resolution of all issues that arise from it, or until the end of the five (5) year period, or such other period required by State or federal law, whichever is later. The requirement specified above pertains to the retention of records for Medicaid purposes; other State or federal rules may require longer retention periods. Current State law (S.C. Code Ann. § 44-115-120) requires physicians to retain their records for at least ten (10) years for adult patients and thirteen (13) years for minors, commencing from the last date of treatment.

(c) Access. Provider acknowledges and agrees that the State, SCDHHS, the United States Department of Health and Human Services, CMS, the Office of Inspector General, the State Comptroller, the State Auditor's Office, the South Carolina Attorney General's Office, Health Plan, Subcontractor, and/or any designees of the above, have the right to evaluate, through audit, inspection, or other means, whether announced or unannounced, any records pertinent to the State Contract, including those pertaining to the quality, appropriateness and timeliness of services provided pursuant to the State Contract, and the timeliness and accuracy of encounter data and practitioner claims submitted by Provider to Subcontractor or Health Plan. Provider shall cooperate with all such audits, evaluations and inspections, including making office work space available for any of the above-named entities or their designees when the entities are inspecting or reviewing any records related to the provision of services under the State Contract. Such entities shall have the right to examine and make copies, excerpts or transcripts from all records; contact and conduct private interviews with Provider and Provider's clients and employees; and do on-site reviews of all matters relating to service delivery as specified in the State Contract. If Provider stores records on microfilm or microfiche, Provider shall produce, at Provider's expense, legible hard copy records within fifteen (15) calendar days of a request by State or federal authorities. The audit and inspection rights specified in this provision shall continue for a period of five (5) years from the expiration date of the State Contract (including any extensions thereof). SCDHHS and/or any designee will also have the right to:

(i) Inspect and evaluate the qualifications and certification or licensure of Provider;
(ii) Evaluate, through inspection of Provider's facilities or otherwise, the appropriateness and adequacy of equipment and facilities for the provision of quality health care to Covered Persons;
(iii) Evaluate Provider's performance for the purpose of determining compliance with the requirements of the State Contract;
(iv) Audit and inspect any of Provider's records that pertain to health care or other services performed under the State Contract, and determine amounts payable under the State Contract;
(v) Audit and verify the sources of encounter data and any other information furnished by Health Plan in response to reporting requirements of the State

Contract, including data and information furnished by Subcontractor and Provider; and

(vi) Monitor enrollment and termination practices and ensure proper implementation of Health Plan's grievance procedures, in compliance with 42 CFR §§438.226 – 438.228, as may be amended from time to time. SCDHHS and/or its designees shall have access to all information related to complaints and grievances filed by Covered Persons.

(d) Records Upon Termination. In the event the State Contract is terminated, Provider shall immediately make available to SCDHHS, or its designated representative, at no expense and in a usable form, any or all records, whether medical or financial, related to Provider's services provided pursuant to the Agreement. The provision of such records shall be at no expense to SCDHHS.

3.10 Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with the State Contract and applicable federal and State privacy laws and regulations, including but not limited to 42 CFR §438.224, 42 CFR Part 431, Subpart F, and the SC Code of Regulations 126-170 *et seq*., as may be amended from time to time. This shall include complying with the following confidentiality requirements under the State Contract:

(a) Provider shall release medical records of Covered Persons only in accordance with applicable State and federal law, including as may be authorized by the Covered Person or as may be directed by authorized personnel of SCDHHS or appropriate agencies of the State or federal government. Release of medical records shall be consistent with the provisions of confidentiality expressed in the State Contract, including those set forth in subsection (b) below.

(b) Provider shall assure that all material and information, in particular information relating to Covered Persons or potential Covered Persons, that is provided to or obtained by or through Provider's performance under the State Contract, whether verbal, written, electronic file, or otherwise, shall be reported as confidential information to the extent confidential treatment is provided under State and federal laws. Provider shall not use any information so obtained in any manner except as necessary for the proper discharge of Provider's obligations and securement of Provider's rights under the Agreement. All information as to personal facts and circumstances concerning Covered Persons or potential Covered Persons obtained by Provider shall be treated as privileged communications, shall be held confidential, and shall not be divulged without the written consent of SCDHHS or the Covered Person/potential Covered Person, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify particular individuals. The use or disclosure of information concerning Covered Persons or potential Covered Persons shall be limited to purposes directly connected with the administration of the State Contract.

3.11 Provider acknowledges and agrees that federal and State laws, regulations and guidelines pertaining to the Medicaid Program and Medicaid Managed Care Organizations, including those required by the State Contract, apply to Provider. Provider shall comply with all State and federal laws, regulations and guidelines applicable to the provision of services under the Medicaid Program, including but not limited to, 42 CFR 434 and 42 CFR 438.6, as may be amended from time to time, to the extent applicable to Provider in performance of the Agreement. Provider must be eligible to participate in the Medicaid Program.

3.12 In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider acknowledges and agrees that such PIP must comply with the State Contract, 42 CFR Part 434, 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither Health Plan, Subcontractor nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. To the extent applicable, Provider shall cooperate with Health Plan and Subcontractor in providing reports and information requested by SCDHHS with regard to any PIP.

3.13 To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and re-credentialing requirements and nondiscrimination. If Subcontractor has delegated credentialing to Provider in accordance with the terms of the State Contract and the contract between Subcontractor and Health Plan, Subcontractor will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Health Plan's and the State Contract's credentialing requirements. Any delegated credentialing activities shall be set forth in the Agreement or other written delegation agreement or addendum between Subcontractor and Provider and SCDHHS shall have final approval of Provider as a delegated entity.

3.14 Provider shall comply with all relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

3.15 Provider shall comply with the following provisions regarding lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying. Provider agrees, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering

into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If the value of the Agreement exceeds $100,000, Provider agrees to complete and submit to Health Plan and Subcontractor the certification required under 31 U.S.C. Section 1352 and 45 CFR Part 93.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.16 Provider represents that neither it nor any of its principals, providers with whom it contracts, if any, employees or subcontractors is debarred, suspended or otherwise excluded from participation in any state or federal health care program, including the Medicaid and Medicare programs, or by any state or federal agency. Provider also represents that neither it nor any of its providers or subcontractors have a Medicaid contract with SCDHHS that was terminated, suspended, denied, or not renewed as a result of any action of CMS, the U.S. Department of Health and Human Services, or the Medicaid Fraud Unit of the Office of the South Carolina Attorney General. Providers who have been sanctioned by any state or federal controlling agency for Medicaid and/or Medicare fraud and abuse and who are currently under suspension shall not be allowed to participate in the Medicaid Program.

Prior to hiring an employee or contracting with a provider or subcontractor, Provider shall check the Excluded Parties List Service administered by the General Services Administration to ensure it does not employ individuals or contract with subcontractors or providers who are debarred, suspended, or otherwise excluded from participating in federal procurement activities and/or have an employment, consulting, or other agreement with debarred individuals for the provision of items and services that are significant to Provider's obligations under the Agreement. Provider shall immediately report to Subcontractor and Health Plan any employees, providers or other subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

3.17 As required under State or federal law or the State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to Subcontractor and Health Plan to submit to the Medicaid Program for prior approval. All marketing and educational materials must be approved by SCDHHS prior to use and all marketing, advertising and Covered Person education activities must comply with instructions as specified in the MCO Policy and Procedure Guide.

3.18 Provider shall perform all services under the Agreement in accordance with the South Carolina State Plan for Medical Assistance under Title XIX of the Social Security Act. Provider shall render Covered Services to Covered Persons through the last day of the month that the Agreement is in effect, pursuant to the State Contract. Provider acknowledges and agrees that all final Medicaid benefit determinations are within the sole and exclusive authority of SCDHHS or its designee.

3.19 Provider shall be currently licensed and/or certified under applicable State and federal statutes and regulations and shall maintain throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities covered under the Agreement, and as defined and required by the State Contract and the standards specified in the MCO Policy and Procedure Guide, Provider Certification and Licensing. If Provider performs laboratory services, Provider shall meet and comply with all applicable State and federal requirements, such as the Clinical Laboratory Improvement Act. Provider shall submit evidence of such qualifications on request. Provider and its employees shall also comply with applicable law, professional ethics and practice standards.

3.20 Provider shall cooperate with Health Plan's and Subcontractor's quality improvement and utilization review and management activities as described in applicable provider manual(s), policies and procedures, the Agreement, and this Appendix. This shall include, but not be limited to, participation and cooperation in, whether announced or unannounced, any internal and external quality assessment review, utilization management, peer review, and grievance procedures established by Health Plan, Subcontractor and/or SCDHHS or its designee. Provider shall adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined in SCDHHS's MCO Policy and Procedure Guide, attached to this Appendix as Exhibit A.

3.21 As required by the State Contract, in accordance with the requirements of SC Code Ann. § 38-33-130(B), as amended from time to time, Provider agrees that in no event, including, but not limited to, non-payment in whole or part of amounts due under the Agreement, insolvency of Health Plan or Subcontractor or breach of the Agreement, shall Provider bill, balance bill, charge, collect a deposit from, seek compensation or payment by, or have recourse against a Covered Person or any persons or entities, including the State, other than Health Plan or Subcontractor, for Covered Services rendered pursuant to the State Contract. Provider shall accept payment from Health Plan or Subcontractor, as the case may be, as payment in full for Covered Services and shall not solicit or accept any surety or guarantee of payment by Covered Persons. This provision does not prohibit Provider from collecting from Covered Persons any cost sharing that is expressly permitted under the State Contract. Any cost-sharing imposed shall be in accordance with 42 CFR §§ 447.50 through 447.58. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law.

For purposes of this hold harmless provision "Covered Person" shall be read to include the Covered Person, his/her parent(s), guardian(s), spouse or any other individual legally responsible for the Covered Person. This hold harmless provision shall survive the termination of the

Agreement and shall be construed for the benefit of Covered Persons. This section supersedes all contrary agreements now existing or hereafter created between Provider and Covered Persons or persons acting on their behalf. As required by SCDHHS under the State Contract, the Agreement and this Appendix is supplemented by the Hold Harmless Agreement in the form attached hereto as Exhibit B in compliance with SC Code Ann. § 38-33-130(B).

3.22 Provider shall secure all necessary liability and malpractice insurance coverage as is necessary to adequately protect Covered Persons and Health Plan with respect to performance of services by Provider pursuant to the State Contract. This shall include securing and maintaining throughout the term of the Agreement and any renewal thereof 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 Provider, or its officers, directors, employees or agents in connection with Provider's activities under the Agreement. Such general liability insurance shall have limits sufficient to cover any loss or potential loss resulting from performance under the Agreement. The amount of malpractice insurance coverage secured by Provider shall be in an amount set forth in the Agreement or as otherwise required under State law. Prior to the effective date of the Agreement, Provider shall provide Subcontractor written verification of the existence of the coverage required under this provision. Provider shall provide Health Plan and Subcontractor at least ten (10) days notice of any cancellation, reduction, or material change in any such coverage. Provider shall indemnify and hold harmless SCDHHS from any liability arising out of Provider's untimely failure in securing adequate insurance coverage as prescribed in this section.

3.23 At all times during the term of the Agreement, Provider shall indemnify, defend, protect and hold harmless SCDHHS and any of its officers, agents and employees from:

(a) any claims for damages or losses arising from services rendered by Provider or by other persons or firms performing or supplying services, materials or supplies on behalf of Provider in connection with the performance of the Agreement and this Appendix;

(b) any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid laws or regulations, by Provider or its agents, officers, employees or subcontractors in performance of the Agreement and this Appendix;

(c) any claims for damages or losses resulting to any person or firm injured or damaged by Provider or its agents, officers, employees or subcontractors by the publication, translation, reproduction, delivery, performance, use or disposition of any data processed under the Agreement or this Appendix in a manner not authorized by the Agreement, this Appendix, or by federal or State statute or regulation;

(d) any failure of Provider or its agents, officers, employees or subcontractors to observe federal or State laws including, but not limited to, labor laws and minimum wage laws;

(e) any claims for damages, losses or costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of SCDHHS in connection with the defense of claims for such injuries, losses, claims or damages specified above; and

(f) any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may, in any manner, accrue against SCDHHS or its agents, officers or employees through the intentional conduct, negligence or omission of Provider, or its agents, officers, employees or subcontractors.

(g) In the event of circumstances not reasonably within the control of Provider, Health Plan, Subcontractor or SCDHHS, (i.e. major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection), neither Provider, Health Plan, Subcontractor or SCDHHS will have any liability or obligation on account of reasonable delay in providing or arranging for Covered Services; provided, however that so long as Health Plan's certificate of authority remains in full force and effect, Health Plan shall be liable for Covered Services required to be provided or arranged for in accordance with the State Contract.

3.24 Provider shall give Health Plan and Subcontractor immediate notification in writing by certified mail of any administrative legal action or complaint filed against Provider and prompt notice of any claim made against Provider by a subcontractor or by or on behalf of a Covered Person which may result in litigation related in any way to activities under the Agreement.

3.25 As required by the State Contract, Provider represents and warrants that it currently has no interest and shall not acquire an interest, direct or indirect, which would conflict in any manner or degree with performance of Provider's services under the Agreement, and shall not employ an individual having any such known interest.

3.26 Provider shall not enter into any subsequent agreement or subcontract for performance of its obligations under the Agreement without Health Plan's and Subcontractor's prior written approval, nor shall Provider assign its duties or responsibilities under the Agreement without the prior written consent of Health Plan and Subcontractor.

3.27 Provider shall promptly submit any and all information necessary for Health Plan or Subcontractor, as the case may be, to make payment. Provider shall submit all claims for payment in accordance with the terms of the Agreement, but in any event no later than twelve (12) months from the date of service.

3.28 Provider shall perform those services set forth in the Agreement.

3.29 As required by the State Contract, Provider shall submit all reports, clinical information and data required by Health Plan and Subcontractor, including all required encounter data and EPSDT reports, if applicable. Provider shall also report the required immunization data to the State Immunization Information System administered by the South Carolina Department of Health and Environmental Control. If Provider has entered into a capitated reimbursement arrangement with Subcontractor, Provider shall submit all encounter data to the same standards

of completeness and accuracy as required for proper adjudication of Medicaid fee-for-service claims.

3.30 Provider acknowledges and agrees that no person, on the grounds of handicap, age, race, color, religion, sex, or national origin, shall be excluded from participation in, or be denied benefits of, Health Plan's Medicaid managed care program, or be otherwise subjected to discrimination in the performance of services under the State Contract or in the employment practices of Provider. Provider shall post in conspicuous places, available to all employees and applicants, notices of non-discrimination and shall, upon request, show proof of such non-discrimination to Health Plan and Subcontractor.

3.31 Provider shall cooperate fully with Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the State Contract and shall cooperate and assist the Medicaid Program and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and federal health care programs.

SECTION 4
HEALTH PLAN AND SUBCONTRACTOR REQUIREMENTS

4.1 Health Plan or Subcontractor shall pay Provider pursuant to the State Contract, applicable State law and regulations, and 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. Unless an alternative payment schedule is set forth in the Agreement, Health Plan or Subcontractor, as the case may be, shall pay 90% of all clean claims from Provider, within thirty (30) days of the date of receipt, and shall pay 99% of all clean claims from Provider within ninety (90) days of the date of receipt. The date of receipt is the date that Health Plan or Subcontractor, as the case may be, receives the claim, as indicated by its data stamp on the claim. The date of payment is the date of the check or other form of payment. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Health Plan or Subcontractor otherwise requests assistance from Provider, Health Plan will be responsible for third party collections in accordance with the terms of the State Contract.

4.2 Neither Health Plan nor Subcontractor shall prohibit or otherwise restrict Provider, when acting within the lawful scope of Provider's license or certification under applicable State law, from advising a Covered Person about the Covered Person's health status, medical care, or treatment for the Covered Person's condition or disease, regardless of whether benefits for such care or treatment are provided under the Covered Person's benefit plan.

4.3 Neither Health Plan nor Subcontractor shall discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of such provider's license or certification under applicable State law, solely on the basis of such license or certification. This provision does not prohibit Health Plan from limiting its network to the extent necessary to serve Covered Persons' needs and is not intended to, nor shall it interfere

with, measures established by Health Plan or Subcontractor to maintain quality of care practice standards or control costs.

4.4 Neither Health Plan nor Subcontractor shall discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments.

4.5 In addition to Subcontractor's termination rights under the Agreement, Health Plan shall have the right to revoke any functions or activities delegated to Provider under the Agreement or impose other sanctions consistent with the State Contract if in Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate.

4.6 Nothing in the Agreement or this Appendix shall be construed as restricting Provider from contracting with another managed care organization or managed care entity for provision of services under the Medicaid Program; nor is Health Plan or Subcontractor required to contract exclusively with Provider for provision of services under the Medicaid Program.

4.7 If Provider is a FQHC/RHC, Health Plan and Subcontractor shall adhere to federal requirements for reimbursement of FQHC/RHC services and the agreed upon payment to the FQHC/RHC shall be set forth in the Agreement. Any bonus or incentive arrangements made to a FQHC/RHC associated with Covered Persons shall also be specified to SCDHHS. Payment to a FQHC/RHC shall not be less than the level and amount of payment made for similar services furnished by a provider that is not an FQHC or RHC. Payment to a FQHC/RHC also shall not be less than the level and amount of payment the FQHC/RHC would have been entitled to receive as reimbursement from the Medicaid Program for a fee-for-service claim. Health Plan or Subcontractor shall submit the name of each FQHC/RHC and the number of Medicaid encounters paid to each FQHC/RHC by month of services to SCDHHS for State Plan required reconciliation purposes in the format required by SCDHHS, as contained in the MCO Policy and Procedure Guide.

SECTION 5
OTHER REQUIREMENTS

5.1 All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, the applicable provisions of which are incorporated into the Agreement by reference. Nothing in the Agreement or this Appendix relieves Health Plan of its responsibility under the State Contract. If any provision of the Agreement or this Appendix is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement or this Appendix in conflict with those of the State Contract will be considered waived.

5.2 To the extent delegated to Subcontractor by Health Plan and as required under State or federal law or the State Contract, Subcontractor shall monitor quality of services rendered by Provider under the Agreement and initiate a corrective action plan where necessary to improve quality of care consistent with the level of care recognized as acceptable professional practice in the community in which Provider is located and/or the standards of SCDHHS or its designee.

Provider shall comply with any plan of correction initiated by Subcontractor, Health Plan, and/or SCDHHS.

5.3 Provider and Subcontractor shall resolve any disputes that may arise between them in accordance with the terms of the Agreement. The parties agree that no dispute will disrupt or interfere with the provisions of services to Covered Persons, including continuity of care should the Agreement be terminated.

5.4 The method and amount of compensation provided to Provider for performance of services under the Agreement shall be as set forth in the Agreement. The Agreement shall also specify the name and address of the official payee to whom payment shall be made.

5.5 The Agreement and its appendices, including this Appendix, contain all terms and conditions agreed upon by the parties and incorporate by reference all applicable federal and State laws and regulations. Revisions of such laws or regulations shall automatically be incorporated into the Agreement and this Appendix and made effective as of the effective date of the change in law or regulation. In the event that any such changes in the Agreement or this Appendix resulting from revisions in applicable federal or State laws or regulations materially affect the position of either party, the parties agree to negotiate such further amendments as may be necessary to correct any inequities. Other than changes in applicable laws and regulations, no other modification or change of any provision of the Agreement or this Appendix shall be made unless such modification is incorporated and attached as a written amendment to the Agreement signed by the parties. Additional procedures and criteria for any alteration, variation, modification, waiver, extension or early termination of the Agreement shall be as set forth in the Agreement.

EXHIBIT A

SOUTH CAROLINA MEDICAID PROGRAM

QUALITY ASSESSMENT AND UTILIZATION MANAGEMENT REQUIREMENTS

(*This Exhibit supplements the South Carolina Medicaid Program Regulatory Requirements Appendix*)

QUALITY ASSESSMENT AND UTILIZATION MANAGEMENT REQUIREMENTS

All MCOs that contract with the SCDHHS to provide Medicaid MCO Program Services must have a Quality Assessment (QA) and Utilization Management (UM) process that meets the following standards:

1. Comply with 42 Code of Federal Regulations (CFR) 434.34 which states that the MCO must have a quality assessment system that:

   a) Is consistent with the utilization control requirement of 42 CFR 456;
   b) Provides for review by appropriate health professionals of the process followed in providing health services;
   c) Provides for systematic data collection of performance and patient results;
   d) Provides for interpretation of this data to the practitioners; and
   e) Provides for making needed changes.

2. Maintain and operate a Quality Assessment (QA) program which includes at least the following elements:

   a) A quality assessment plan which shall include a statement that the objective of the QA plan is to "monitor and evaluate quality and appropriateness of patient care, pursue opportunities to improve patient care, and resolve identified problems." QA efforts should be health outcome oriented and rely upon data generated by the MCO as well as that developed by outside sources. The plan must be organized and written so that staff members and practitioners can understand the program's goals, objectives and structure and should incorporate information from customer service, appeals and grievances, medical management, credentialing, and provider relations.

   b) QA Staff - The QA plan developed by the MCO shall name a quality director, manager or coordinator responsible for the operation and success of the QA program. Such person shall be a registered nurse, have adequate and appropriate experience to conduct a successful QA program, and shall be accountable for QA in all of the MCOs own providers, as well as the MCOs subcontractors. The person shall spend at least 80% of his/her time dedicated to QA activities to ensure the success of the QA program. . In addition, the medical director must have substantial involvement in QA activities.

   c) QA Committee - The MCO's QA program shall be directed by a QA committee which has the substantial involvement of the medical director and includes membership from:

      - a variety of health professions (e.g., pharmacy, physical therapy, nursing, etc.)
      - a variety of medical disciplines (e.g., medicine, surgery, radiology, etc.). with emphasis on primary care including obstetric and pediatric representation; and
      - MCO management or Board of Directors.

d) The QA committee shall be in an organizational location within the MCO such that it can be responsible for all aspects of the QA program.

e) The QA committee shall meet at least quarterly and produce dated and signed written documentation of all meetings and committee activities. This documentation as well documented QA activities and outcomes shall be submitted on a quarterly basis to the MCO Board of Directors and the SCDHHS authorized agents.

f) The QA activities of MCO providers and subcontractors, shall be integrated into the overall MCO/QA program. The MCO QA Program shall provide feedback to the providers/subcontractors regarding the integration of, operation of, and corrective actions necessary in provider/subcontractor QA efforts.

g) The MCO shall have a written procedure for implementing the findings of QA activities, and following up on the implementation to determine the results of QA activities. Follow-up and results shall be documented in writing, and copies provided to both the MCO Board of Directors and the SCDHHS.

h) The MCO shall make use of the SCDHHS utilization data or their own utilization data, if equally or more useful than the SCDHHS utilization data, as part of the QA program.

i) Quality Assessment and Performance Improvement Program (QAPI): The Contractor shall have an ongoing quality assessment and performance improvement program for the services it furnishes to members. At a minimum, the Contractor shall:

- Conduct performance improvement projects as described in Item (l) of this Section. These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have favorable effect on health outcomes and enrollee satisfaction.
- Submit performance measurement data as described in Item (k) of this Section.
- Have in effect mechanisms to detect both under-utilization and over-utilization of services.
- Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

j) Performance Measurements: Annually the Contractor shall:

1. Measure and report to SCDHHS its performance using ALL NCQA defined HEDIS measures applicable to Medicaid by June 15th of the following calendar year. Reporting must use the NCQA definitions for that respective measurement year (i.e. 2009 data must use 2009 definitions.)
2. Perform a combination of the activities described in the two items k(1) and k(2) listed above.

k) Performance Improvement Projects (PIP): Annually, the Contractor shall have an ongoing program of performance improvement projects (a minimum of one project

and a maximum of three projects) that focus on clinical and non-clinical areas, and involve the following:

- Quantitative and Qualitative measurements of performance using standard objective quality indicators.
- Implementation of system interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

These projects must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have favorable effect on health outcomes and enrollee satisfaction.

l) In future contracts, pay-for-performance will be used to access the quality improvement measured in HEDIS and CAHPS survey.

3. Assist the SCDHHS in its quality assurance activities.

   The MCO will assist, in a timely manner, the SCDHHS and the External Quality Review Organization (EQRO) under contract with the SCDHHS, as needed, in identification of provider and recipient data required to carry out on-site medical chart reviews.

   The MCO will arrange orientation meetings for physician office staff concerning on-site medical chart reviews, and encourage attendance at these meetings by MCO and physician office staff, as needed.

   The MCO will assist the SCDHHS and the EQRO under contract with the SCDHHS, as needed, in securing records needed to conduct off-site medical chart reviews.

   MCO will facilitate training provided by the SCDHHS to its providers.

   MCO will allow duly authorized agents or representatives of the State or Federal government, during normal business hours, access to MCO's premises or MCO subcontractor premises to inspect, audit, monitor or otherwise evaluate the performance of the MCOs or subcontractors contractual activities.

   When deficiencies are found, the MCO will submit a Plan of Correction which includes the following:

   - Identifies each deficiency
   - Specifies the corrective action to be taken
   - Provides a timeline by which corrective action will be completed.

4. Assure that all persons, whether they be employees, agents, subcontractors or anyone acting for or on behalf of the provider, are properly licensed and/or certified under applicable state law and/or regulations and are eligible to participate in the Medicaid/Medicare program.

The MCO must have written policies and procedures for credentialing and recredentialing. The MCO may use its own Credentialing Form or the South Carolina Uniform Managed Care Provider Credentialing Application developed by the South Carolina Medical Association. The MCO may use its own Re-Credentialing Form or the South Carolina Uniform Managed Care Provider Credentials Update Form also developed by the South Carolina Medical Association. Copies of these may be downloaded at the following site: http://www.scmca.org/download/UCA2004.pdf.

The MCO shall maintain a copy of all plan providers current valid license to practice.

The MCO shall have policies and procedures for approval of new providers and termination or suspension of a provider.

The MCO shall have a mechanism for reporting quality deficiencies which result in suspension or termination of a provider.

5. The MCO must have systems in place for coordination and continuation of care to ensure well managed patient care, including at a minimum:

   (a) Written policies and procedures for assigning every member a primary care provider.
   (b) Management and integration of health care through primary care providers. The MCO agrees to provide available, accessible and adequate numbers of institutional facilities, service location, service sites, professional, allied, and paramedical personnel for the provision of covered services, including all emergency services, on a 24-hour-a-day, 7-day-a-week basis.
   (c) Systems to assure referrals for medically necessary, specialty, secondary and tertiary care.
   (d) Systems to assure provision of care in emergency situations, including an education process to help assure that members know where and how to obtain medically necessary care in emergency situations.
   (e) Specific referral requirements for in and out of plan services. MCO shall clearly specify referral requirements to providers and subcontractors and keep copies of referrals (approved and denied) in a central file or the member's medical record.
   (f) The MCO must assign an MCO qualified representative to interface with the case manager for those members receiving out of plan continuity of care and case management services. The MCO representative shall work with the case manager to identify what Medicaid covered services, in conjunction with the other identified social services, are to be provided to the member.

6. The MCO shall have a system for maintaining medical records for all Medicaid members in the plan, to ensure the medical record:

   (a) Is accurate, legible and safeguarded against loss, destruction, or unauthorized use and is maintained, in an organized fashion, for all individuals evaluated or treated, and is accessible for review and audit. Also, the MCO shall maintain, or require its network providers and subcontractors to maintain, individual medical records for each Medicaid member which make readily available to the SCDHHS and/or its designee and to appropriate health professionals all pertinent and sufficient

information relating to the medical management of each enrolled member. Procedures shall also exist to provide for the prompt transfer of patient care records to other in - or out-of-plan providers for the medical management of the member.

(b) Is readily available for MCO-wide QA and UM activities and provides adequate medical and other clinical data required for QA/UM.

(c) Has adequate information and record transfer procedures to provide continuity of care when members are treated by more than one provider.

(d) Contains at least the following items:

- √ Patient's name, identification number, age, sex, and places of residence and employment. Next of kin, sponsor or responsible party.
- √ Services provided through the MCO, date of service, service site, and name of service provider.
- √ Medical history, diagnoses, treatment prescribed, therapy prescribed and drug administered or dispensed, commencing at least with the first patient examination made through or by the MCO.
- √ Referrals and results of specialist referrals.
- √ Documentation of emergency and/or after-hours encounters and follow- up.
- √ Signed and dated consent forms.
- √ For pediatric records (ages 6 and under) there must be a notation that immunizations are up-to-date.
- √ Documentation of advance directives, as appropriate.
- √ Documentation for each visit must include:
  - Date
  - Grievance or purpose of visit
  - Diagnosis or medical impression
  - Objective finding
  - Assessment of patient's findings
  - Plan of treatment, diagnostic tests, therapies and other prescribed regimens.
  - Medications prescribed
  - Health education provided
  - Signature and title or initials of the provider rendering the service. If more than one person documents in the medical record, there must be a record on file as to what signature is represented by which initials.

7. Submit Encounter Data as required on a monthly basis. This data shall be submitted in a format as specified by SCDHHS.

(a) The MCO must report EPSDT and other preventive visit compliance rates.

(b) All MCO contracts with network providers/subcontractors shall have provisions for assuring that data required on the encounter report is reported to the MCO by the network provider/subcontractor.

(c) For the purposes of reporting individuals by age group, the individual’s age should be the age on the date of service

8. The MCO shall have written utilization management policies and procedures that include at a minimum:

   (a) Protocols for denial of services, prior approval, hospital discharge planning and retrospective review of claims.
   (b) Processes to identify utilization problems and undertake corrective action.
   (c) An emergency room log, or equivalent method, specifically to track emergency room utilization and prior authorization (to include denials) reports.
   (d) Processes to assure that abortions comply with 42 CFR 441 subpart E-Abortions, and that hysterectomies and sterilizations comply with 42 CFR 441 subpart F-Sterilizations.

9. The MCO shall furnish Medicaid members with approved written information about the nature and extent of their rights and responsibilities as a member of the MCO. The minimum information shall include:

   (a) Written information about their managed care plan,
   (b) The practitioners providing their health care,
   (c) Information about benefits and how to obtain them,
   (d) Confidentiality of patient information,
   (e) The right to file grievance about the MCO and/or care provided,
   (f) Information regarding advance directives as described in 42 CFR 417.436 and 489 subpart I,
   (g) Information that affects the members enrollment into the MCO

10. Establish and maintain grievance and appeal procedures. The MCO shall:

   (a) Have written policies and procedures which detail what the grievance system is and how it operates. The grievance procedures must comply with the guidelines outlined in the Contract.
   (b) Inform members about the existence of the grievance processes.
   (c) Attempt to resolve grievances through internal mechanisms whenever possible.
   (d) Maintain a record keeping system for oral and written grievances and appeals and records of disposition.
   (e) Provide to SCDHHS on a quarterly basis written summaries of the grievances and appeals which occurred during the reporting period to include:
      - Nature of grievances and/or appeals
      - Date of their filing
      - Current status
      - Resolutions and resulting corrective action

   The MCO will be responsible for forwarding any adverse decisions to SCDHHS for further review/action upon request by SCDHHS or the Medicaid MCO Program member.

   (f) Notify the member who grieves, that if the member is not satisfied with the decision of the MCO, the member can make a request to the Division of Appeals and Hearings, SCDHHS. for a State fair hearing. If the grievance/appeal is not resolved during the fair hearing, the Grievant/Appellant may request a reconsideration by SCDHHS, or file an appeal with the Administrative Law Judge Division.

11. The SCDHHS is required to evaluate each MCOs compliance with SCDHHS program policies and procedures, identify problem areas and monitor the MCOs progress in this effort. At a minimum this will include, but is not limited to,:

    (a) SCDHHS will review and approve the MCOs written Quality Assurance Plan. The MCO must submit any subsequent changes and/or revisions to its Quality Assurance Plan to SCDHHS for approval on or before April 30th annually.
    (b) The SCDHHS will review and approve the MCOs written grievance and appeal policies and procedures. The MCO must submit any subsequent changes and/or revisions to its Grievance and Appeal Policy and Procedures to SCDHHS for approval prior to implementation.
    (c) The SCDHHS shall review monthly individual encounter/claim data. Encounter claim data shall be reported in a standardized format as specified by SCDHHS and transmitted through approved electronic media to SCDHHS.
    (d) The SCDHHS shall review quarterly quality measure reports. The reports will be submitted to SCDHHS in the format specified by SCDHHS.
    (e) SCDHHS staff will review the MCOs reports of grievances, appeals, and resolution.
    (f) SCDHHS staff will approve the MCOs Plan of Correction (PoC) and monitor the MCOs progress with the corrective actions developed as a result of the annual external QA evaluation or any discrepancies found by the SCDHHS that require corrective actions.

12. External Quality Assurance Review. Annually, the SCDHHS will conduct an independent review of services provided or arranged by the MCO. The review will be performed by the External Quality Review Organization (EQRO) under contract with the SCDHHS. External quality assurance evaluation and EQRO responsibilities shall include:

    - Readiness Review Survey. The EQRO will conduct a readiness review of the Contractor as designated by DHHS. The Medicaid Managed Care External Review Services Manual will serve as a guide for the readiness review survey. DHHS will receive a written report within 30 days of the survey. DHHS will convey the final report findings to the MCO with a request for a PoC.
    - Effective January 1, 2013, verify the most recent NCQA Accreditation survey and corresponding status. This survey is conducted every three years by NCQA and is required for plans to serve as contractors to SCDHHS. Prior to this date, verification of the most recent NCQA or URAC Accreditation survey and status with those organizations.
    - With SCDHHS staff, conduct workshop and training for MCO staff regarding the abstraction of data for the quality of care studies and other features of the annual QA evaluation.

    SCDHHS will evaluate the MCOs compliance with the QA standards through an annual comprehensive QA evaluation. The Medicaid Managed Care External Review Audit Tool will serve as a guide for the annual review.

NCQA HEDIS Reporting Measures

Use guidelines for HEDIS measures defined by NCQA for that respective measurement year (i.e. measures reported in 2010 are for the 2009 measurement year and must follow the specifications published for that measurement year). Measures must be submitted to SCDHHS by June 15th of the following calendar year (the reporting year). Data must be submitted to SCDHHS in XML format. A timeline for submitting HEDIS and CAHPS survey measures is published by the NCQA, and should be followed to ensure timely submission.

2011 Timeline:

- Use the services of a contracted NCQA accredited compliance auditor or schedule a certified HEDIS Compliance auditor for the calendar year.
- Collect measures January 1, 2010 – December 31, 2010.
- Audit collection process by NCQA certified auditor.
- Do chart review for hybrid measures. In the event that a MCO does not have a contract with an NCQA accredited vendor for auditing, this will be arranged by SCDHHS, and fees for auditing will be paid to SCDHHS to pay for auditing services.
    - NCQA data software is available to help with data processing.
- Submit measures to NCAQA.

June 15th 2011:

- Submit finalized measures to SCDHHS in XML format used for submission to NCQA.

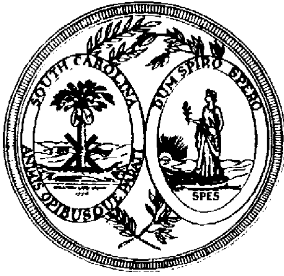
While not necessary for 2009 measurement year data, it is highly recommended that HEDIS and CAHPS reports are generated and reported in 2010 for data and quality improvement purposes.

EXHIBIT B

SOUTH CAROLINA MEDICAID PROGRAM

SOUTH CAROLINA HOLD HARMLESS AGREEMENT

(*This Exhibit supplements the South Carolina Medicaid Program Regulatory Requirements Appendix pursuant to* SC ST § 38-33-130(B))



Form SCID 505

State of South Carolina
Department of Insurance

HOLD HARMLESS AGREEMENT

In accordance with the requirements of S.C. Code Ann. Section 38-33-130 (B) (1976, as amended), and as a condition of participation as a health care provider in Unison Health Plan of South Carolina, Inc. (hereinafter the "HMO"), the undersigned

(Name of HMO)

Provider (hereinafter "Provider") hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees of the HMO or persons acting on their behalf, for health care services which are rendered to such enrollees by Provider, and which are covered benefits under enrollees' evidence of coverage. This agreement extends to all covered health care services furnished to the enrollee during the time he is enrolled in, or otherwise entitled to benefits promised by the HMO. This agreement further applies in all circumstances including, but not limited to, non-payment by the HMO and insolvency of the HMO.

This agreement shall not prohibit collection of copayments from enrollees by Provider in accordance with the terms of the evidence of coverage issued by the HMO. The Provider further agrees that this agreement shall be construed to be for the benefit of enrollees of the HMO and that this agreement supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and such enrollees, or persons acting on their behalf.

Provider's Name: ______________________________
(Please type)

Signature: ____________________________________

Title (if applicable): ______________________________

Date: ____