Change Control Record

Date	Section(s)	Page(s)	Change
04-01-25	4.2.22.7	45	Updated HCNE chart
01-01-25	Throughout		Changing document name from Policy and Procedure Manual to Process and Procedure Manual
	2.7.2.4	22	Addition of PT Compact language allowances
	3.11.2.1.4	31	Addition of Inmate Member Disenrollment procedures
	4.2.22.9	48	Addition of 340B program requirements
	4.2.22.15	49	Addition of additional outpatient drug requirements to be effective no later than July 1, 2025
	7.3	66-68	Incentive Payment language moved to Section 15 of the MCO contract and Section 15.7 of the P&P (pg. 153-154)
	7.3.1.4	68	MCO Withhold and MCO Withhold Return language moved to Section 15.6.1.2 of the P&P (pg. 152-153)
	7.4.1.1	70-71	Removal of specific dates relating to state-directed payment program
	7.4.1.4	72-73	Independent Community Pharmacy Directed Payment program language moved higher in the section
	11.1.13	102	Overpayment language moved to MCO contract
	15.7.1	153-155	Update to PCMH NCQA recognition standards
	15.7.1	156	Addition of PCMH Incentive Payment Reporting Schedule
	15.10	159	Physician Incentive Plan language moved from Section 18 of the P&P; the language mirrors updated language in Section 15 of the MCO contract.
10-01-24	Throughout		Additional titles for sections have been added throughout
	4.2.20	41	Definitions for IOP/PHP have been added
	6.2	61	Updates made to Network Adequacy Analysis Report submission timeline
	7.4; 14.8	155-161	Removal of RHC/FQHC Wrap payments/ encounters from Encounters section. Any missing information seen in the Encounters section was added to Section 7, Payments.
	Section 13	144-146	Minor updates to the reports chart
	15.9	172-176	Language in Section 16.7 reorganized to Section 15.9

Change Control Record

7-1-2024	Title Page	Title Page	Updated date of document
	2.7	8-11	Moved requirements of NPs as providers of health care services to top of section.
	3.2	15-17	Moved maximum member enrollment requirements to top of section.
	4.2.12	28-29	Added requirement for plans to allow 12-month supply of birth control pills to be dispensed at a time.
	4.2.21	32	Added requirement for plans to adhere to the Managed Care Contract for the Preferred Drug List.
	4.2.21.3-4	34	Rewrote language surrounding 72-hour emergency supplies of medication.
	4.2.21.10	34	Cited link to fhsc.com for additional guidelines to providing MAT services.
	4.2.21.10.2	35	Changed Buprenorphine monotherapy to not needing prior authorization.
	4.2.24.4	39	Added reference to Appendix for info on SAMSHA and NIDA-recognized risk factors.
	7.4.2.3	62	Moved information surrounding annual wrap-around reconciliation report to before chart.
	11.10.1	104-107	Inclusion of chart format for the different composite score measures in SPLIP criteria.
	14.6.2	151	Reformatted data elements for non-par provider file into a list.
	15.6	167	Added scale of one index score section in the definition of improvement for the withhold index.
	15.9	169	Added language to give requirements, but not limitations, to external quality reviews.
	18.3.16	178	Added title for Physician Incentive Plan Sanctions
	Appendix 4	214	Moved Alcohol and Other Drug (AOD) Risk Factors by Domain into the Appendix
1-1-2024	The Enrollment Process	3-4	Updated the enrollment process for prospective MCOs. Added a section about network adequacy.
	The Enrollment Process	5	Referenced a project plan and readiness tool and updated the URL for the Managed Care Reports Companion Guide.
	4.2.4	26	Added section to cover maintenance of cochlear implants.
	4.2.21	34	Deleted bullet about 17-P Makena universal auth form.

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	4.2.21.6	39	Submitted additions to the high cost no experience drug list
	4.2.25	46	Change in MCO responsibility for transplants effective 2-1-24.
	4.3.5	47	Changed the date for changes to the health plan comparison chart to September.
	4.4.2	51	Added MCOs are responsible for payments to DECs effective 2-1-24.
	7.4.1.1	75	Changed the Teaching Physician and HAWQ payments to 30 days (versus 45) after remittance is received. Added that CEO can sign the attestation.
	7.4.1.1	76	Changed FY 2024 expected date of payment to providers for the teaching physician directed payments to the 1st versus 15th. Updated chart to reflect the 30 versus 45 days.
	7.4.2.3	78	Deleted the previous wraps payment methodology table.
	7.4.2.3	78-79	Added the FQHC Wrap payment methodology table and footnotes.
	7.4.3.3	82	Deleted the previous wraps payment methodology table.
	7.4.3.3	82-83	Added the RHC Wrap payment methodology table and footnotes.
	7.12	86	Changed the Independent Community Pharmacy payments to 30 days (versus 45) after remittance is received. Added that CEO can sign the attestation.
	7.12	87	Changed FY 2024 expected date of payment to independent community pharmacies to the 1st versus 15th.
	12.3	136	Added MCO bi-yearly distribution of educational materials requirement.

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	12.4	138	Edited the Plan Codes and added examples to better explain how to notate Sequence.
	13.1	142	Deleted the Makena/17P report form the table.
	13.1	146	Changed the Quality assessment and improvement projects from ad hoc/as necessary to quarterly.
	14.8	151	Deleted the previous wrap payment methodology table.
	14.8	152-153	Added the FQHC Wrap payment methodology table and footnotes.
	14.8	156	Deleted the previous wrap payment methodology table.
	14.8	156-157	Added the RHC Wrap payment methodology table and footnotes.
	15.6	166	Changed the section title to Quality Withhold and Bonus Program.
	15.6	167-168	Deleted the previous Quality Withhold Indices and Bonus Pool Measures.
	15.6	169-170	Updated the wording to reflect index (versus composite) and updated step 3 for calculating the withhold. Deleted the example under transition year.
	15.7	172	Added detail to the paragraph regarding requesting additional information about value-based contracting.
	15.9	175	Added a bullet, U, regarding mental health parity requirements.
10-1-2023	2.2	5	Added language requiring a monthly submission of the Key Personnel Changes report.

Commented [KV1]: Blackline I looked at had 167 and 168 as blank pages. Formatting?

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	2.7	9	Added information to licensing requirement for an Individual Pharmacist who is enrolling for the ability to provide hormonal contraception services in accordance with the Pharmacy Access Act.
	4.2.21.6- 4.2.21.6.1	37	New Drugs added to the High Cost No Experience Drug list
	7.4.1.1	72	Updated language to reflect HAWQ program to identify that the State Directed Payment is approved by CMS
	7.4.1.1	72	Updated language previously defining State Directed Payment attestations to be signed by the Chief Medical Officer to reflect Chief FINANCIAL Officer
	7.4.1.1	73	Updates to FY2024 HAWQ Hospital Directed Payment Schedule.
	13.1.2	136	Added language updating listing of required reports to include the Key Personnel Changes report added 10-1-2023 to section 2.2 of the contract
	13.1.2	138	Added previously required Case Management Program Description to the listing of required reports.
7-1-2023	3.3.1-3.3.4	13	Modified language in Step 1 of the quality weighted assignment algorithm to include the word remaining.
	3.14	20	Removed naming convention information and referred users of the guide to find the information in section 12.4 of the guide. This information was listed in two separate sections. The language was modified in section 12.4 as referenced below.
	4.2.5	25	Added LEA manual to the list of manuals containing the full array of Behavioral Health Services the MCOs are responsible for.
	4.2.6	26	Updated sites to reflect 4.2.6 - 4.2.8.1
	4.2.21.6 – 4.2.21.6.1	36	Updated HCNE listing for the Pharmacy Risk Mitigation Program. Dates were updated to reflect historical date ranges. New drugs were also added to the current listing.
	4.2.25	41-42	Updated language related to authorization of transplants as well as information concerning MCO and FFS responsibility for payment responsibilities.

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	5.7	51	Added language related to Case Management for Members Enrolled in Foster Care and referenced a new monitoring tool that will be used by SCDHHS that will be published in the Report Companion Guide.
	7.3	70	Update to section titled Capitation Payments made for Waiver and Hospice Membership, which requires provider adjustments to be initiated within 6 months of notice from the Department.
	7.4.1.1	71	Updated language to define the current State Directed Payments for Hospitals. Teaching Physician Directed Payment and the HAWQ program. Also edited the Payment Schedules to reflect the current State Directed Payment Programs for SFY 2024
	7.9.2	81	Removed reference to AT-C Section 205A, 105A and 315.
	7.12	81	Added language defining the SFY 2024 Independent Community Pharmacy State Directed Payment Program.
	8.3	83	Added requirement for submission of Service Authorization Report.
	12.3	129	Updated Paragraph A under Permitted Activities to increase maximum give-a-way item fair market value from $10.00 to $15.00.
	12.3	131	Under Social Media Activity section, removed the language stating that SCDHHS will respond to requests and submissions by the MCO within five (5) Business Days.
	12.4	132-133	Updated naming convention requirements for Marketing material submission by the MCO to SCDHHS.
	13.1.2	137-140	Updated Report Table to include quarterly and annual submission of Service Authorization Report under Section 8. Additionally, under Section 13 of the Table, the SCDOI/NAIC reporting was added which was already a requirement. Added to listing to reflect previous addition of this requirement in the MCO contract. Lastly, in the Notes Section of the Table, reference to the 2014 MCO Contract/Policy and Procedure Guide was removed.
	15.5	156	Identified the NCQA HEDIS Tech Specs as the source for defining measures submitted to SCDHHS for the particular Measurement Year.
	15.6	157-162	Update to entire section to reflect most recent MY and future MY requirements for the Quality Measurement and Withhold Programs.

Change Control Record

Date	Section(s)	Page(s)	Change
1-1-2023	2.3	5	Expanded reference to include through 2.3.1.4
	4.2.5	28	Expanded reference to include through 4.2.5.5
	4.2.21	38	Expanded reference to include through 4.2.21.11
	5.2	49	Expanded reference to include through 5.2.2
	6.1	52	Expanded reference to include through 6.1.13
	6.3	65	Expanded reference to include through 6.6
	Definition of Terms	193	Added Definition of LTSS
7-1-22	2.6	6	Modified subcontractor to In Network Provider
	2.7	6	Section eliminated
	2.7	7	Added In Network Provider
	3.3.1-3.3.4	15	Relocated Maximum member enrollment section 3.10 to this section
	3.10	20	Section moved

Change Control Record

Date	Section(s)	Page(s)	Change
	3.11-3.17	20-23	Numbering changes for the rest of section 3
	4.2.12-4.2.12.3	29	Modified family planning definition.
	4.2.21.6-4.2.21.6.1	37	Update to the High Risk No Experience Pharmaceutical table.
	4.2.27	42	Description of vaccine services modified.
	6.1-6.1.8	52	Redefined Subcontractor to In Network Provider
	6.3	64-65	Aligned section with contract to account for quarterly network submissions.
	7.3.1-7.3.8	69	Replaced Milliman with SCDHHS actuary
	7.4	70	Redefined Subcontractor to In Network Provider
	7.4.1.1	71	Modified the directed payment program descriptions and instructions.
	7.4.2.3	74	Modified the RHC Wrap template
	7.4.2.3	79	Modified the FQHC Wrap template
	7.9	83	Modified language for readability

Change Control Record

Date	Section(s)	Page(s)	Change
	7.9.2	84	Added additional instruction regarding the independent audit parameters.
	10.4.4	90	Added School Based Mental Health Services to the list of services that are allowable as pay and chase methodology and does not require cost avoidance.
	11.12.10	127	Modified language to align with new contractual numbering.
	13.1.3-13.1.10.5	140	Numbering change to section
	13.1.3-13.1.10.5	140	Modified table for ongoing monthly PRTF report
	14.2&14.3	141	Numbering change to section
	14.6.2-14.6.14.2.1	143-144	Added additional detail specifications on encounters to be submitted, future processes if the department elects to receive denied encounters and the day of the month that encounters must be submitted by in order to be included for the monthly data load.
	14.8.2	146	Modified the FQHC Wrap template
	14.8.2	149	Modified the RHC Wrap template
	14.9.1.1.4	152	Deleted cite
	14.13	154	Deleted cite. Numbering changes for rest of section due to deletion.
	15.5-15.10	158-171	Numbering modifications

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Date	Section(s)	Page(s)	Change
	15.9	167-169	Redefined Subcontractor to In Network Provider
	19	180-183	Numbering modifications
	Appendix A	184-206	Definitions of terms modified. Added BabyNet, In Network Provider, Negative PDL Change. Modified Family planning, Health Record, Incentive Arrangement, Inmate, Referral Services, and Subcontractor. Eliminated Cold Call Marketing.
4-1-22	4.2.25-4.2.25.5	41	Removed the word choices from South Carolina Healthy Connections Medicaid
	9.1	82	Modified the reporting elements due to the implementation of the new Grievance and Appeal Report.
	7.4.1.2	71	Removed sentence that indicated the final true up would be in August. Based on the current preprint true up will come later in the year. Also modified dates in the table on same page.
	10.4	86-87	Removed the word choices from South Carolina Healthy Connections Medicaid
	10.5	88	Removed the word choices from South Carolina Healthy Connections Medicaid
	11.10	111	Removed the words by the Department.
	13.1.2	134	Modified the reporting table to include the new Grievance and Appeal Reports (Annual and Quarterly)
	15.6-15.6.2.3	157-160	Added Quality Withhold performance criteria for RY 23/MY22 and RY24/MY23
1-1-22	4.3.6	43	Modifying the enrollment broker benefit grid to amend once a year in January.

Change Control Record

Date	Section(s)	Page(s)	Change
	7.4.2.3	72	Modifying the RHC Wrap files to include the new COVID Vaccine coding.
	7.4.3.2-7.4.3.3	76	Modifying the FQHC Wrap files to include the new COVID Vaccine coding.
	10.4.4	89	Removed Title IV- Child Support Enforcement insurance records
	14.8.2	143-149	Modifying the FQHC and RHC Wrap files to include the new COVID Vaccine coding.
10-1-21	Introduction	1-4	Modified the MCO enrollment requirements
	2.8.2.4-2.8.2.5.3	9	Modified Nurse Practitioner section due to physician oversight changes in the Nurse Practice Act
	3.15	21	Removed WellCare labeling and inserted Humana labeling
	7.4.1.2	71	Modified Hospital Quality Directed Payment Table to ensure complete run out of member and claims data for final FY payment.
	11.1.6	93-97	Changes made to notifying PI and MFCU.
	11.1.10	97	Modification to Good Cause Exception procedures.
	11.1.16	103	Added word “Payment” to SCDHHS Reporting of Suspensions
	12.4	130	Removed WellCare labeling and inserted Humana labeling

Change Control Record

Date	Section(s)	Page(s)	Change
	14.10	151	Added a column for estimated time for EQI template distribution to the MCOs
	15.4	152	Added reporting table for Annual CAHPS data files. These instructions will replace the annual data submission protocol.
	15.5-15.5.3.1	154	Added reporting table for Annual HEDIS data files. These instructions will replace the annual data submission protocol.
	15.7-15.7.5.2	161	Added reporting table for Annual APM reports. These instructions will replace the annual data submission protocol.
	A.1	202	Added an abbreviations section to MCO P&P similar to the one in the MCO Contract.
7-1-21		1	Modified Contract Date to 2021
	2.2.1.1-2.2.1.3	5	Contract numbering change
	2.8.2.4-2.8.2.5.3	8	Removed DHEC survey of RHCs since RHCs are federally defined by CMS.
	3.1	11	Modified language to more accurately reflect nursing home members that may reside in managed care.
	3.3.1-3.3.4	14	Added additional information around new health plan ratings
	3.7	18	Changed American Indians to Native Americans
	3.8	18-20	Relocated the section on member redetermination

Change Control Record

Date	Section(s)	Page(s)	Change
	4.2.5.5	27	Removed PRTF and Autism reporting requirements.
	4.2.12-4.2.12.3	28	Removed bad weblink and replaced with a good weblink.
	4.2.13	28	Added Home Health heading for the section.
	4.2.21.3-4.2.21.3.3	32-35	Relocated pharmacy related requirements to align with July 1, 2021, contract.
	4.2.21.6-4.2.21.6.1	36	Modified HCNE table.
	4.2.23	37	Relocated Sterilization policies so that it was aligned alphabetically and with the contract.
	4.2.27-4.2.28	41-42	Vaccine and vision care services were moved so that they were ordered alphabetically and aligned with the contract.
	6.4.4	63-64	Added language around network assessment and the failure assessment reporting.
	7.2.1.2	65	Modified language regarding where reporting requirements are found for the MLR reports.
	7.3	65-68	Relocated the various gross level adjustment reasons for payments outside of normal capitation.
	7.3.2-7.3.2.2	69	Added language around hospice and waiver cases where premium recoupment will be initiated as a result of members retroactive movement back to FFS Medicaid.
	7.4	71	Modified Hospital Quality Incentive Reporting table and timeframes.

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Date	Section(s)	Page(s)	Change
	7.4	72	Modified RHC wrap table.
	7.4	76	Modified FQHC wrap table.
	11.1	92-104	Modified to align with changes made to the contract.
	11.2	105	Modified to align with changes made to the contract.
	11.4	106	Modified to align with changes made to the contract.
	11.5-11.6	108-109	Modified to align with changes made to the contract.
	11.10	120	Modified to align with changes made to the contract.
	13.2	132-137	Modified report table for changes in the reporting requirements under the new contract.
	14.5	138	Added section 14.5 for testing of encounter data.
	14.8.2	142	Added FQHC wrap methodology table.
	14.8.2	145	Added RHC wrap methodology table.
	18.3	167-170	Moved sanctions language to align with the contract for July 1, 2021.

Change Control Record

Date	Section(s)	Page(s)	Change
	19.36-19.37	174	Added missing sections to the P&P to align with the July 1, 2021, contract.
	Appendix A	184	Added Failure Severity Index definition to contract.
4-1-21	3.4.1-3.4.4	16	Modified section for new plan auto-assignment when the mode and median are not a ranked value in the table.
	4.2.28	42-43	Added a vaccine section to account for COVID vaccines and their administration.
	12.3	125	Added clarifying language to non-permitted marketing activities.
	15.5	152-153	Corrected the reporting year decisions for future withhold metrics which would be for the reporting year 2023 not 2022. Added Quality Withhold process for new MCOs entering the market.
	Appendix 3	199	Changed Transportation Broker name to Modivcare from Logisticare.
01-29-21	3.4.1-3.4.4	16	Eliminated some duplicated language in number 2 on the page.
	4.2.5.4-4.2.5.4.1	27	Modified IMD language for clarification of the IMD 15 day stay limitation.
	4.2.24-4.2.24.5	40	Modified the transplant section to remove definition of Group I vs Group II as the categorization of these Groups is no longer necessary.
	11.1.16	100	Revising requirements due to changes in disclosure of ownership.
	11.2.10-11.2.11.1	104	Revising requirements due to changes in disclosure of ownership.

Change Control Record

Date	Section(s)	Page(s)	Change
	11.11.1-11.11.1.2.6	119	Revising requirements due to changes in disclosure of ownership.
	11.11.1-11.11.1.2.6	120	Revising requirements due to changes in disclosure of ownership.
	11.12.10	121	Revising requirements due to changes in disclosure of ownership.
	11.12.11	121	Revising requirements due to changes in disclosure of ownership.
	13.1.2	130	Modifying chart to include IMD report submission date.
	14.10.8-14.10.8.3	145	Modifying due date for annual EQI when there are five Fridays in the month of January.
	15.5	149-153	Revised this section based on quality changes for new year
	Appendix A	189	Eliminated Qualified Medicaid provider
	Appendix A	191	Added South Carolina Medicaid Network Provider definition
10-01-20	3.1	12	Updated Managed Care eligibility table with Baby Net category
	3.4.1-3.4.4	16	Eliminated date from member enrollment process point number 2 since that date has passed and no longer relevant.
	7.4.1.2	72	Added section regarding the Hospital Incentive Payment process moving to quarterly report distribution for each fiscal year.

Change Control Record

Date	Section(s)	Page(s)	Change
	11.11	121	Corrected a typo at the beginning of paragraph 3 in section.
07-01-20	Contracting Process	2	Deleted “Regardless of Percentage of Ownership” since the federal government has rules around who must disclose.
	2.8.2.4 - 2.8.2.5.3	9	Modified DMH language to acknowledge IMD enrollment and billing procedures
	4.2.16 - 4.2.16.1	30	Corrected a typo redetermination is found twice in same sentence.
	4.2.21.1	32-33	Removed references to the Hep C carve out and included the new Pharmacy Risk Mitigation program.
	4.2.21.8	36	Removed the pharmacy related guidance adding it to the contract.
	4.2.24 - 4.2.24.5	40	Modified notification procedures regarding Out of State Transplant requests. Language now is the same in both Provider Policy and Procedure manuals and MCO Managed Care Policy and Procedure Guide.
	7.3.1.1 - 7.3.2.2	66	Corrected Typo
	7.4.2.3	71	Updated RHC WRAP Schedule for FY 2021
	7.4.3.2 - 7.4.3.3	75	Updated FQHC WRAP Schedule for FY 2021
	7.5	79	Updated the copayment chart based on the changes that were completed in March of this year due to COVID.
	11.1- 11.11.1.2.6	122-123	Modified ownership disclosure language to abide by MPEC rules.

Change Control Record

Date	Section(s)	Page(s)	Change
	13.1.2	134	Updated the Report chart to include the HCNE drug reporting.
	14.8.2	142	Updated FQHC WRAP Schedule for FY 2021
	14.8.2	146	Updated RHC WRAP Schedule for FY 2021
03-30-20	11.1.6	90	Revised Member Investigation of Potential Fraud
	11.1.6	91-93	Newly defined examples of Fraud and Abuse
	11.1.6	94	Revised SCDHHS Responsibilities
	11.1.10	95	Revised language when determining if a CAF exists
	11.1.10	96	Added 2nd paragraph regarding Release of Payments
		98	Modified language under DHHS Compliance Monitoring from provider having to meet 3 consecutive months of 80% clean claims to 3 months of 80% clean claims during the first 6 month of review, and after 12 months of a 6-month evaluation period.
	11.1.16-11.1.16.2	99	Amended language for all PI activities that must be reported superficially to each Report formatting.
	11.4.2.1-11.4.2.2	105	Added section that MCO shall conduct a minimum of twelve (12) provider on-site reviews per year.

Change Control Record

Date	Section(s)	Page(s)	Change
	11.5.3.1	108	Amended language for attendance of all PI scheduled meetings.
	11.6.2.3-11.6.2.3.7	108-109	Added sections regarding SCDHHS analyzing Overpayment made by MCO to a provider.
	15.4	150	Modified the date for Data Submission Protocol to MCOs from April 1 to April 30th
	15.5	154	Modified language that SCDHHS will evaluate results against regional benchmarks as apart of annual HEDIS submissions.
10-1-19	4.2.21.8	36	Added federally required language for Drug Utilization Review to meet requirements.
	15.1.6	145	Amended language in the final sentence in this section to ensure correct reading of the information.
	15.3	145	Modified the date for CAHPS data submission from April 1 to April 30.
	15.3	146	Modified the data submissions to include South Carolina specific CAHPS data.
	15.4	146	Added information on HEDIS measures when NCQA does not require specific measures for accreditation. Added additional information on the Final Audit Report (FAR)
	15.5	147-148	Modified the reporting and measurement years.
	15.5	149-150	Modified the HEDIS measure table and reporting and measurement year.

Change Control Record

Date	Section(s)	Page(s)	Change
	Definitions	172	Modified the Authorized Representative definition so that it is the same definition found in the contract.
07-01-19	Introduction	2	Removed fax and telephone number from introduction
	3.2	13	Added definition to text messaging for MCO members
	3.4.1-3.4.4	15	Added new assignment rules effective 10/1/19
	3.10	20	Maximum enrollment for all MCOs added
	3.13.5-3.13.5.10	21	Added a description of where to find the template for the enrollment brokers provider directory submission
	4.2.5-4.2.5.4	26	Added additional provider manuals covered by behavioral health
	4.2.5.3	27	Added additional section to correspond with contract
	4.2.5.4-4.2.5.4.1	27	Added process for IMD services in excess of 15 days
	4.2.23-4.2.23	36	Numbering change to correspond with contract addition
	10.4.4	84	Removed Maternal Health Services
	10.9.1-10.9.1.4	88	Additional data point added and modified language to coincide with contract language being 365 days for casualty claims.

Change Control Record

Date	Section(s)	Page(s)	Change
	Section 11	89-127	Revised Program Integrity Section
	12.2	128	Removed sentence regarding phone numbers
	13.1	135-140	Modified report table to coincide with changes in reports
	15.6	157	Correction of typo to contract section numbering
04-01-19	4.2.21.3 - 4.2.21.3.3	33-35	Revised Medication Assisted Therapy (MAT) Minimum Coverage Criteria
	4.2.24 - 4.2.24.5	40	Revised Group I – Kidney and Corneal
	13.1.2	133	Revised General Requirements
	Definition of Terms	181	Added Health Care Professional
01-01-19	4.2.21.3 - 4.2.21.3.3	33	Revised Pharmacy / Prescription Drugs
	4.2.23 - 4.2.23.3	35	Revised Alcohol and Other Drug (AOD) Risk Factors by Domains
	11.2.10 - 11.2.11.1	103	Revised Compliance Plan Requirements
	11.12.1 -11.12.5	118	Corrected section numbering

Change Control Record

Date	Section(s)	Page(s)	Change
	11.12.11.1 - 11.12.13	120	Revised CONTRACTOR Providers and Employees – Exclusions, Debarment, and Terminations
	12.2 - 12.2.10	121	Revised Guidelines for Marketing Materials and Activities
	15.5	146-149	Revised Quality Withhold and Bonus Program
10-01-18	3.15.1.2- 3.15.2.10.1	21	Revised Member Communication
	6.2	51-60	Revised CONTRACTOR Provider Network
	7.3.1.1 - 7.3.2.2.	65-66	Revised Provider Quality Incentive Programs
	7.4.3.2	70	Revised Payments from CONTRACTOR to Subcontractors
	7.9.1	76	Revised Periodic and Annual Audits
	11.1.6 11.1.11 11.1.16 11.1.17	88-92 94-97 97, 99 101-102	Revised General Requirements, Program Integrity
	11.2.10 - 11.2.11.1	103	Revised Compliance Plan Requirements
	11.4.2, 11.4.5	104, 105	Revised Reviews, Investigations and Audits
	11.6.3.1.2.2	107	Revised Overpayments, Recoveries, and Refunds
	12.4-12.4.2	126	Revised Marketing Material Submission Requirements

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	13.1.2	128	Revised General Requirements, Reporting Requirements
	14.8.2	138	Revised FQHC / RHC Encounter Reporting
	16.3	158	Revised Notification of Medicaid MCO Program Policies and Procedures
07-01-18	All	-	Revised entire document
01-01-18	11.10	103	Revised Ownership and Control
	13.1.1	116	Revised General Requirements
	14.10.8 – 14.10.8.3	124-125	Revised Data Validation
	15.0	126-133	Revised Quality Management and Performance
	19.4	143	Revised Safeguarding Information

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Date	Section(s)	Page(s)	Change
	Definition of Terms	150	Revised Authorized Representative
10-01-17	2.8.2.4	8	Revised Provider Enrollment and Credentialing
	3.2	12-13	Revised Member Eligibility Redetermination
	4.2.21.2	32-33	Revised Pharmacy / Prescription Drugs
	11.10	104-105	Revised Ownership and Control
	14.5.6 - 14.5.12.1	120	Revised Encounter Data
07-01-17	3.14-3.16, 4.1, 4.2.12, 4.2.21, 4.2.23-4.2.25, 4.2.27, 4.3.7-4.3.7.3, 5.6.6.3-5.6.6.5, 7.3.3.3, 7.10, 7.11, 13.1.10.5 14.1, 14.5.5.2 14.14, 15.2-15.9	19, 21 26, 30 32-36 36 37 45 58, 65 117 117 125-134	Revised numbering to link with contract numbering
	2.8	7	Revised Provider Enrollment and Credentialing
	3.1	11	Revised Member Eligibility
	3.13	18, 19	Revised Member Disenrollment
	3.19	20	Revised Member Call Center
	4.2.5	24-25	Revised Behavioral Health Services
	4.2.14	27	Revised Hysterectomies

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Date	Section(s)	Page(s)	Change
	4.2.27	36, 37	Revised Sterilization
	4.4.2	38	Deleted Autism Spectrum Disorder Services
	6.2	46	Revised Contractor Provider Network
	7.3.1.1	56 58	Revised Incentive Payments Deleted Centering Program
	7.4.3.2	61	Revised Payments from Contractor to Subcontractors
	7.5	63-64	Revised Co-payments
	7.9	65	Added Periodic and Annual Audits
	9.1.3.1-9.3.1.1.1	66-68	Revised Member Grievance and Appeal System
	10.1	75	Revised General
	11.1.10	76	Revised General Requirements
	12.3.2-12.3.4	108	Revised Marketing Plan Requirements
	13.1	113-114	Revised General Requirements
	14.8.6	119-120	Revised FQHC / RHC Encounter Reporting
	14.10	123-124	Revised Data Validation
	14.13	125	Revised Periodic Audits
	15.2	125	Deleted Quality Assessment and Performance Improvement (QAPI)
	19.35	154-177	Revised Definition of Terms
04-01-17	2.8	9	Revised Provider Enrollment and Credentialing

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Date	Section(s)	Page(s)	Change
	5.5.3 - 5.5.5.2.2	44	Revised Continuity of Care Management Activities
	7.3	57-59	Revised Capitation Payments from the Department to CONTRACTOR
	9.1.6.3.1.1	70	Revised Member Grievance and Appeal System
	11.4.2	90	Revised Reviews, Investigations and Audits
	11.8	94	Revised Suspension of Payment Based on Credible Allegation of Fraud
	11.10	104	Revised. Ownership and Control
	14.5.6 - 14.5.12.1	119-120	Revised Encounter Data
	14.10	126	Revised Data Validation
01-01-17	4.2.1	22	Revised Abortions
	7.2.2	58	Revised Centering Program
	11.1	83	Revised General Requirements – Provider Reviews Monthly Reports
		86	Revised General Requirements – SCDHHS Reporting of Suspensions
	11.4	89-89	Revised Reviews, Investigations and Audits
	12.0	105-110	Revised Marketing Program

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Date	Section(s)	Page(s)	Change
	13.1	113	Revised General Requirements – Table
	14.10	122-123	Revised Data Validation
	15.6	127-128	Revised Quality Withhold and Bonus Program -
10-11-16	-	-	MCO Policies and Procedures effective July 1, 2016,
05-01-16	3.2.7 - 3.2.7.4	13	Revised Member Auto-Assignment (Non-Newborns)
	6.1.1.10	53-57	Revised General Requirements (Provider Network Adequacy Determination Process)
	7.2.2	68	Revised Centering Program
	7.3.1 - 7.3.1.4	72	Revised Payments from CONTRACTOR to Subcontractor - Background
	14.2.4.1, 14.2.15	107, 108	Revised Encounter Data
	14.3.6.3.1	109	Revised Errors and Encounter Validation
04-01-16	14.2	109	Revised Encounter Data
03-01-16	4.19	46	Revised Broker-Based Transportation (Routine Non-Emergency Medical Transportation)
	7.2.2	69	Revised Centering Program
		72	Revised MCO Withhold
	11.7	97	Revised Ownership and Control
	14.3.1.1	118	Revised Errors and Encounter Validation

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Date	Section(s)	Page(s)	Change
02-01-16	4.1	21	Revised Ambulance Transportation
	4.18.6	45	Revised Additional Services
	7.2.2	68	Revised Patient Centered Medical Home (PCMH)
	10.9.2- 10.9.2.1.4	84-85	Revised Reporting Requirements
	12.3.1	104	Revised Guidelines for Marketing Materials and Activities
	14.2.1-14.2.4.1	108	Revised Encounter Data
	14.3.6.9 - 14.3.6.9.3	111	Revised Errors and Encounter Validation
12-01-15	3.2.3.2.5 - 3.2.4.3.2	10-12	Revised Enrollment Process
	11.5	91, 93	Revised Recoveries and Provider Refunds
	11.6	93-94, 95-96	Revised Reporting Requirements for Program Integrity
11-01-15	2.2.1.10	4, 5	Revised Contractor Administration and Management
	3.1	9	Revised Enrollment
	3.2, 3.2.7 - 3.2.7.4	10-11	Revised Enrollment Process
	4.1	23	Revised Core Benefits for the South Carolina Medicaid MCO Program – Hysterectomies, Sterilizations, and Abortions
	7.2	63	Revised Capitation Payments from the Department to CONTRACTOR - Retrospective Review and Recoupment

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Date	Section(s)	Page(s)	Change
	7.3.2	71	Revised FQHC/RHC Wrap Data Files (Spreadsheets)
	14.3.6.3.1	106-107	Revised Errors and Encounter Validation
10-01-15	4.1	24	Revised Core Benefits for the South Carolina Medicaid MCO Program – Abortions
	4.17.1-4.17.8	40	Revised Member Incentives
	4.18	41	Revised Additional Services
	7.2.2	63-64	Revised Patient Centered Medical Home (PCMH)
	11.0	80-93	Revised entire section
	12.3	95	Revised Guidelines for Marketing Materials and Activities
09-01-15	3.1.1	7	Replaced Managed Care Eligibility and Eligibility Categories table
	4.1	19	Revised Core Benefits for the South Carolina Medicaid MCO Program – Ancillary Services
		23	Revised Core Benefits for the South Carolina Medicaid MCO Program – Hysterectomies
		24-25	Revised Core Benefits for the South Carolina Medicaid MCO Program – Abortions
	6.1.1.10	27	Revised MCO Credentialing Committee and the Credentialing Process
	7.2.2	40-42	Revised Centering Program

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Date	Section(s)	Page(s)	Change
	7.3	45	Revised Payments from CONTRACTOR to Subcontractor
	9.1	47-49	Revised Member Grievance and Appeal
	9.2	49-50	Revise Provider Dispute System
	11.6	67	Revised Reporting Requirements for Program Integrity
	13.1.1	78	Revised General Requirements
08-01-15	14.2.1-14.2.4.1	105	Revised Encounter Data
07-01-15	4.19	42	Revised Autism Spectrum Disorder Services
	7.2.2	62, 63, 65	Revised Capitation Payments from the Department to CONTRACTOR
	7.6	69	Revised heading to Return to Funds
	15.6.1	114, 117, 118	Revised Quality Withhold and Bonus Programs
06-01-15	2.2, 3.8, 3.13, 4.18, 5.1-5.3, 6.3, 7.2, 7.5-7.6, 11.7, 11.10-11.12, 12.3, 14.1	5, 15, 17-18, 41, 47-49, 61, 67, 69, 93, 95-96, 97, 104-105	Revised the numbering to link with contract numbering
	3.2	11	Revised Enrollment Process
	3.4	13-14	Revised Notification to MCO of Membership

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Date	Section(s)	Page(s)	Change
	3.7	14-15	Revised Redetermination Notice
	4.1	31	Revised Core Benefits for the South Carolina Medicaid MCO Program — Prescription Drugs
	4.19	42	Revised Excluded Services to add Autism Spectrum Disorder Services
	6.1	52	Revised General Requirements (Provider Network Adequacy Determination Process)
	6.2	58	Revised Provider Network
	6.3	61	Added Attestations
	14.1	105	Revised Encounter Data
	15.6	115-119	Revised Quality Withhold and Bonus Programs — NCQA HEDIS Reporting Measures
05-01-15	13.1.1	102	Revised General Requirements
	14.3.1.1-14.3.5	105	Revised Errors and Encounter Validation
	15.6.1	111-113	Revised Quality Withhold and Bonus Programs
	15.7.4	116	Value Oriented Contracting (VOC)
04-01-15	2.2	5	Revised Contractor Administration and Management
	2.4	6	Revised Subcontractor Requirements
	3.10	15	Revised Provider Directory
	3.13	17	Revised Member Communications

Change Control Record

Date	Section(s)	Page(s)	Change
	6.1	51	Revised MCO Credentialing Committee and the Credentialing Process
	6.2	55	Revised Provider Network
	6.3	60	Deleted sample Attestation Statement
	7.2	61	Revised Retrospective Review and Recoupment – Dual Eligible
	12.3	102-103	Revise Guidelines for Marketing Materials and Activities
	15.6	109	Revised Quality Withhold and Bonus Programs
03-01-15	4.1	26	Revised Inpatient Hospital Services
	7.2	62, 65	Revised Capitation Payments from the Department to CONTRACTOR
	12.3	102	Revised Beneficiary Marketing and Member Education Materials/Media
	13.1	104	Revised General Requirements
	14.3.6.3.1	107	Revised Errors and Encounter Validation
02-01-15	4.1	18, 26	Revised Core Benefits for the South Carolina Medicaid MCO Program
	4.19	44	Revised Excluded Services
	6.1	53	Revised MCO Credentialing Committee and the Credentialing Process
	7.2	62-63	Revised Retrospective Review and Recoupment – Dual Eligible

Change Control Record

Date	Section(s)	Page(s)	Change
	11.2	82	Revised CONTRACTOR Requirements
01-01-15	3.8	14	Revised Member Call Center
	7.2	63	Retrospective Review and Recoupment – Dual Eligible
	7.3	69	Payments from Contractor to Subcontractor
	14.2	107	Encounter Data
12-15-14	-	-	****New** MCO Policies and Procedures effective July 1, 2014**
06-01-14	Appendix 5	134	Revised Withhold for Quality Performance Measures
05-01-14	5.4	30	Revised Managed Care Enrollment Period
	10.11	44	Revised Home Health Services
	10.27	53-54	Revised Substance Abuse Services
	Appendix 5	130	Revised Centering Program
01-01-14	10.26	53	Revised Vision Care Services
11-01-13	Cover		Replaced SCHC logo and remove MCO logo
	3.2	21	Added new section Enrollment Broker Updates for Managed Care Organizations
	4.2	25	Revised MCO Credentialing Committee and the Credentialing Process
	15.0	79-91	Revised Program Integrity Policies and Procedures – Managed Care Fraud and Abuse Complaints and Referrals

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Date	Section(s)	Page(s)	Change
	25.0	106, 110 107 109	• Added definitions for Medicaid Fraud Control Unit (MFCU) and Surveillance and Utilization Surveillance and Utilization Review System (SURS) • Moved Member Handbook definition beneath Medicare • Revised Protected Health Information (PHI) definition
09-01-13	6.7	34-35	Revised FQHC/RHC Wrap Payment Process
	10.9	43	Revised Family Planning
	Appendix 5	119 125 125	• Revised provider designated and MCO designated incentives • Revised Withhold for quality Performance Measures • Disposition of Undistributed Withhold Funds
08-01-13	2.0	4, 5	Added form number to Disclosure of Ownership and Control Interest Statement
	2.1	5	Revised Required Submissions
	10.25	51	Revised Transplant and Transplant-Related Services
	10.27	52	Added Substance Abuse Services
	13.0	59	Revised Quality Assessment and Utilization Management Requirements
	14.1-Appendix 4	73, 74, 76, 94, 109	Replaced “Certificate of Evidence of Coverage” with “Member Handbook”
	Appendix 5	118, 120	• Revised Patient Centered Medical Home (PCMH) • Revised Centering Pregnancy Incentive (formerly Centering Program)
05-30-13	Appendix 5	117	Revised Patient Centered Medical Home (PCMH)

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Date	Section(s)	Page(s)	Change
05-24-13	6.7	34	Revised Background Information
	7.0	34	Revised Grievance (Complaint)
	14.3	73	Revised Beneficiary Marketing and Member Education Materials/Media
	20.0	90	Removed Daily Newborn Enrollee file from Summary of Required Files, Reports, and Forms tables
	21.1	91	Revised the definition of beneficiary
	Appendix 5	117	Revised Patient Centered Medical Home (PCMH)
	19.0	86-87	Revised Pay for Performance Process (CRCS Reporting)
	Appendix 5	122	Revised penalty for low performance measurements
03-12-13	4.1	23	Revised Initial Credentialing and Recredentialing Policy
	11.1	52	Revised Mental Health Authorization or Provided by State Agencies
	Appendix 5	117 122	• Revised Patient Centered Medical Home (PCMH) • Revised Withhold for Quality Performance Measures
03-01-13	2.7	9-10	Revised New Boilerplate Subcontract
	2.8	10	Revised Contract Update Process
	2.9	10	Revised MCO Communications to Providers
	2.11	13	Corrected Specialists table entries
	4.2	24-26	Revised MCO Credentialing Committee and the Credentialing Process

Change Control Record

Date	Section(s)	Page(s)	Change
	6.1	33	Revised Retrospective Review and Recoupment – Dual Eligible
	6.8	34	Added **new** section: Affordable Care Act (ACA) Primary Care Enhanced Payments for Eligible Primary Care Physicians
	10.21	49	Revised Prescription Drugs
	10.25	52	Revised Transplant and Transplant-Related Services
	10.27	53	Deleted section for DAODAS (Alcohol and Drug Abuse Services)
	11.1	53	Changed section heading to Mental Health and Alcohol and Other Drug Abuse Treatment Services Authorized or Provided by State Agencies
	11.8	56	MAPPS Family Planning Services
	14.4	75	Revised General Marketing/Advertising and Medicaid MCO Member Education Policies
	18.1	86	Revised section heading to Pay for Performance (CRCS Reporting)
	19.0	87	Revised Summary of Required Files, Reports, and Forms table
	20.0	88	Revised definition for SCDHHS
	Appendix 5	117-123	Revised Incentives and Withholds Requirements
	Appendix 6	123-124	Revised Quality Weighted Auto Assignments
01-01-12	10.27	53	Added **new** section for DAODAS (Alcohol and Drug Abuse Services)
	11.1	54	Removed DAODAS language from Mental Health section

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

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

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

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

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Date	Section(s)	Page(s)	Change
06-01-12	1.0	3	Added Corrective Action Plan (CAP) policy
	9.1.2	42	Added Back Transfers section
04-01-12	2.3	7	Deleted requirement for one (1) PCP per 2500 Medicaid MCO members
	2.11	14	• Added the following network providers to the subcontractor spreadsheet: Licensed Independent Social Worker, Licensed Professional Counselor, Licensed Marriage & Family Therapist, and Psychologist • Changed Psychiatry (private) status from 3 to 1
	6.1	34	Deleted Low Birth Weight and Very Low Birth Weight Kicker Payment Process section
	9.19	49	Remove mental health, therapeutic, and rehabilitative services language
	9.20	49	Removed payment language for medical services provided by psychiatrist or child psychiatrist
	9.23	51	Renamed heading and updated language for psychiatric services
	10.2	53	Changed heading and language to include services authorized or provided by state agencies
	10.2.1	53	Deleted – Hospital Services (UB-04 Claims)
	10.2.2	53	Deleted – Physicians/Clinic (CMS-1500 Claims)
	12.0	65	Changed the age for recording immunization status in the pediatric record to under the age of 19
	Appendix 4	106 112, 115, 117,	• Added definition of a clean claim • Updated language in the following requirements: D.8, E.10, G.8, H.2, H.3

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Date	Section(s)	Page(s)	Change
02-01-12	7.0	40	Updated working and added a paragraph to Grievances and Appeals
	2.7	10	Removed options for New Boilerplate Subcontract
	4	23	Updated outpatient hospital provider information
12-01-11	2.7	10-11	Added additional subcontractor boilerplate requirements
	13.6	81-82	• Changed section name to "Focus Group and Member Surveys • Updated section to include member survey language
	14	110-120	Added Appendix 4, Subcontract Boilerplate Requirements
11-01-11	Table of Contents	-	Updated to reflect reorganization of the document
	1.0, 2.0	2-4	Changed "Division of Care Management" to "Division of Managed Care"
	2.10	12	Added language to ensure MCOs receive approval by county for each provider network from SCDHHS before executing contracts
	2.12	17	Added Requirements for the Utilization of Nurse Practitioners (NPs) as Providers of Health Care Services section
	3.0	19-20	Updated network termination and transition language
	3.1	20-21	Added Voluntary Termination of a County(ies) section

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Date	Section(s)	Page(s)	Change
	4.0–4.2	21-26	Updated provider certification and licensing language
	9.0–9.25	41-56	Rearranged and revised Core Benefits section
	14.0–14.2	83-84	Renamed section heading and revised language
	18.0	92	Changed claims completeness rate to 97 % instead of 95 %
	20.0	96, 97, 101, 102	Added the following definitions: • Certified Nurse Midwife/Licensed Midwife • Certified Registered Nurse Anesthetist (CRNA)/Anesthesiologist Assistant (AA) • Medical Doctor • Nurse Practitioner and Clinical Nurse Specialist • Physician's Assistant
08-01-11	6.0	33	Added paragraph for the Universal 17-P Universal Authorization form
	19.0	95	Updated second paragraph for monthly files/reports
06-01-11	7.1	35	Updated first paragraph of Current Medicaid Service Limitations
	7.3	35	Updated first paragraph of Kidney section
	18.0	94	Changed heading from “Pay for Reporting Process” to ”Pay for Performance Process” and updated section language
	19.0	95	Updated Index of Required Files, Reports, and Forms section, paragraph. 2
05-01-11	2.3	8	Added new paragraph at the end of the section to include MCO redetermination policy

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Date	Section(s)	Page(s)	Change
	3.8	25	Deleted bullet #2 to remove language allowing MCOs to disenrollment a Medicaid MCO Member due to the member's failure to follow the rules of the Managed Care Plan