DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Hess / Hutto	4-4-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000316	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Mr. Keck, Singleton, Cannon, Campbell Closed 6/26/13, e mails attached	[X] Prepare reply for appropriate signature DATE DUE 4-17-13 [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

Brenda James

From: Deirdra Singleton
Sent: Thursday, April 04, 2013 6:47 PM
To: Jan Polatty
Cc: Brenda James
Subject: RE: Office of Inspector General Evaluations of State Medicaid Programs

Yes, pls log Roy/Jennifer for managed care and Beth/Mike for provider ownship info

From: Jan Polatty
Sent: Thursday, April 04, 2013 8:54 AM
To: Deirdra Singleton
Cc: Brenda James
Subject: Fwd: Office of Inspector General Evaluations of State Medicaid Programs

Hey, I think this should be logged. Thanks

Sent from my iPad

Begin forwarded message:

> **From:** Info Info <info@scdhhs.gov>
> **Date:** April 3, 2013, 10:31:52 AM EDT
> **To:** Jan Polatty <POLATTYJ@scdhhs.gov>
> **Subject: FW: Office of Inspector General Evaluations of State Medicaid Programs**

> **From:** Greiber, Vincent W (OIG/OEI) [mailto:Vincent.Greiber@oig.hhs.gov]
> **Sent:** Tuesday, April 02, 2013 3:17 PM
> **To:** Info Info
> **Cc:** Davis, Hailey E (OIG/OEI); Sayer, Janna (OIG/OEI)
> **Subject:** Office of Inspector General Evaluations of State Medicaid Programs
>
> Dear Mr. Keck,
>
> Thank you for your continued participation in the Office of Inspector General evaluations of State Medicaid programs. Attached is a request for your participation in two online surveys related to the two ongoing evaluations: (1) State agencies' collection and verification of provider ownership information, and (2) State standards for access to care for Medicaid managed care beneficiaries. Please use the following instructions to login to complete these two online surveys before **April 19, 2013.**
>
> *Instructions:*
>
> 1. **State agencies' collection and verification of provider ownership information**

To access this survey, click the following link:

https://surveys.oig.hhs.gov/snapwebhost/surveylogin.asp?k=136379943696

In the STATE ABBREVIATION field enter your State's two-letter abbreviation in capital letters (**SC**); you will not need to enter a password to complete this survey. You may find it helpful to have available state laws and regulations and department policies and procedures relevant to the provider ownership disclosure requirements (42 CFR § 455.104). Throughout the survey, we will ask for these documents to be emailed.

If you have any questions about this survey, please contact Janna Sayer, Program Analyst, at Janna.Sayer@oig.hhs.gov or 1-800-334-4878.

2. **Access to providers enrolled in Medicaid managed care plans**

To access this survey, click the following link:

https://surveys.oig.hhs.gov/snapwebhost/surveylogin.asp?k=136484261154

In the USERNAME field enter your State's two-letter abbreviation in capital letters (**SC**); you will not need to enter a password to complete this survey. Also attached is a reference copy of the survey questions, which includes the list of managed care organizations that we have selected for this evaluation. You may find it helpful to have available the following documents as you complete the survey; we will ask you to submit these documents at the end of the survey:

1. Documentation of your State's standards for access to care, pursuant to 42 CFR §§ 438.202-210.

2. Documentation of any other standards your State may have related to access to managed care.

3. Documentation of the strategies that your State has to assess whether MCOs in your State meet these standards for access to care, including external quality review (EQR) reports and other strategies.

4. Documentation of each instance between January 1, 2008 and January 1, 2013 in which your State identified an MCO that was not meeting the State's standards for access to care, if applicable.

5. Documentation of each action taken between January 1, 2008 and January 1, 2013 against an MCO that was not meeting the State's standards for access to care, if applicable.

6. Documentation of your State's broader efforts to ensure that beneficiaries enrolled in Medicaid managed care have access to care.

If you have any questions about this survey, please contact me at Vincent.Greiber@oig.hhs.gov or call me at (212) 264-5034.

Thank you again,

Vince

Vincent Greiber
Program Analyst

Office of Inspector General
Department of Health and Human Services
26 Federal Plaza, 41-106
New York, NY 10278

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

April 2, 2013

Anthony Keck
Director
State of South Carolina,
Department of Health & Human Services
1801 Main Street PO Box 8206
Columbia, SC 29201-8206

Dear Mr. Keck:

The Department of Health and Human Services, Office of Inspector General, Office of Evaluation and Inspections is conducting two national evaluations related to State Medicaid Agency providers:

1. State agencies' collection and verification of provider ownership information. *To login to this online survey, enter the following URL into your browser:* https://surveys.oig.hhs.gov/snapwebhost/surveylogin.asp?k=136379943696

2. Access to providers enrolled in Medicaid managed care plans. *To login to this online survey, enter the following URL into your browser:* https://surveys.oig.hhs.gov/snapwebhost/surveylogin.asp?k=136484261154

As part of these evaluations, we are requesting that all State Medicaid Agencies complete two online surveys and provide supporting documentation. Your participation is critical. **These surveys should be completed no later than April 19, 2013.**

The first survey is about how State Medicaid Agencies and their respective managed care plans collect and verify Medicaid provider ownership disclosures. The second survey focuses on State standards for access to providers enrolled in Medicaid managed care plans.

Both surveys must be completed online. To access the online surveys, click on each link in the email or enter the URL above into your browser. You may forward each link to the appropriate person in your agency. **Note that once you have begun the survey, you can close it and return to complete it at another time.** Further details on how to complete the surveys are included on the survey's web pages.

If you have any questions about the Provider Ownership Survey, please contact Janna Sayer at 1-800-334-4878 or Janna.Sayer@oig.hhs.gov. If you have any questions about the Access to Managed Care Survey, please contact Vincent Greiber at (212) 264-5034 or Vincent.Greiber@oig.hhs.gov.

The authority for this evaluation is found in the Inspector General Act (Act) (5 U.S.C. App. 3) at sections 2, 4 and 6 of the Act, which authorize the Inspector General to conduct inquiries and make recommendations relating to the economy, efficiency, and effectiveness of programs administered or funded by HHS. Additional authority is found in Title II of the Health Insurance Portability and Accountability Act (also known as HIPAA) (see 42 U.S.C. §1320a-7c(a)), which directs the Attorney General and the HHS Inspector General (on behalf of the Secretary), to establish a health care fraud and abuse control program that includes, in part, "conduct[ing] investigations, audits, evaluations and inspections relating to the delivery of and payment for health care."

Under the health information privacy regulation that implements HIPAA, providing the information requested by OIG is a permitted disclosure since it is required by law to be produced to the OIG as part of your participation in a government benefits program (see 45 C.F.R. §§ 164.512(a), 164.103) and will be used for health oversight activities by OIG, which meets the definition of a "health oversight agency" (see 45 C.F.R. §§ 164.512(d), 164.501).

Thank you for your cooperation.

Sincerely,

Dwayne Grant
Regional Inspector General
for Evaluation and Inspections

ACCESS TO MEDICAID MANAGED CARE
Survey of State Medicaid Agencies

Thank you for your participation in the Office of Inspector General (OIG) survey of State Medicaid Agencies. This survey focuses on State standards for access to care for Medicaid managed care beneficiaries. Federal regulations require that States develop a written strategy—which must include standards for access to care—for assessing and improving the quality of managed care services offered by all managed care organizations (MCOs) (see 42 CFR §§ 438.202-210).

If you have any questions about the survey, please contact Vincent Greiber at (212) 264-5034 or Vincent.Greiber@oig.hhs.gov.

The following survey includes questions on your State's comprehensive risk-based MCOs and your State's standards for access to care in these MCOs. The first section asks you to provide specific information on MCO(s) in your State, including enrollment in each as of January 1, 2012. The second section asks you to describe the specific standards for access to care developed by your State. The third section asks you to describe your State's broader efforts to ensure beneficiary access to managed care providers. The fourth section asks you to describe any barriers to access and include any additional comments you may have regarding access to care.

At the end of this survey, you will be asked to submit the following documentation, which may also be helpful to have available as you complete the survey.

1. Documentation of your State's standards for access to care, pursuant to 42 CFR §§ 438.202-210, that are relevant to the MCOs selected for this evaluation. (See the list of selected MCOs on page 2.)

2. Documentation of any other standards your State may have related to access to managed care (e.g., waiver authority documentation, contracts with MCOs selected for this evaluation).

3. Documentation of the strategies that your State has to assess whether the MCOs selected for this evaluation meet these standards for access to care, including external quality review (EQR) reports and other strategies.

4. Documentation of each instance between January 1, 2008 and January 1, 2013 in which your State identified any of the MCOs included in this evaluation (see the list of MCOs on page 2) as not meeting the State's standards for access to care.

5. Documentation of each action taken between January 1, 2008 and January 1, 2013 against any MCO included in this evaluation that was identified as not meeting the State's standards for access to care, if applicable.

6. Documentation of your State's broader monitoring and oversight efforts to ensure that beneficiaries enrolled in Medicaid managed care have access to care.

Section 1: Managed Care Organizations (MCOs)

The table below includes the names of your State's MCOs that have been selected for our evaluation. Please complete the table for each MCO listed below.

	State/ MCO Plan Name		What populations are served by this plan? *(Please check the box next to each population that is served by the plan. If the plan only serves Medicaid beneficiaries, only check the box next to Medicaid.)*	How many Medicaid beneficiaries were enrolled in this plan as of January 1, 2012? *(Please do not include CHIP beneficiaries.)*	Name of Plan Contact Person	Email Address of Plan Contact Person	Telephone Number of Plan Contact Person	Through what date do you expect this plan to remain active in your State?
1	SC	ABSOLUTE TOTAL	☐ Medicaid ☐ CHIP ☐ Medicare ☐ Commercial					
2	SC	BLUECHOICE MEDICAID	☐ Medicaid ☐ CHIP ☐ Medicare ☐ Commercial					
3	SC	FIRSTCHOICE	☐ Medicaid ☐ CHIP ☐ Medicare ☐ Commercial					
4	SC	UNITED	☐ Medicaid ☐ CHIP ☐ Medicare ☐ Commercial					

1.1. Does your State have a definition for "primary care provider" (i.e., specific provider types that are considered primary care providers by your State)?

☐ Yes → Please provide your State's definition.
☐ No → *Go to Question 1.2.*

1.2. Please describe how Medicaid managed care beneficiaries in your State **select their primary care provider (PCP).** (For example, are Medicaid managed care beneficiaries given a list of providers from which they choose their PCP, or are beneficiaries auto-assigned to a PCP?) If this process differs by plan within your State, please identify the plan and describe its process for each plan mentioned above.

1.3. Please describe the **specialty care referral process** for each Medicaid managed care plan in your State. (For example, must PCPs provide a referral for a beneficiary to see a specialty care provider? If so, how does the specialty care provider know a referral was made? In what instances can beneficiaries contact a specialty care provider without a referral from their PCP?)

Section 2: State Standards for Access to Care

Federal regulations require that States develop a written strategy—which must include standards for access to care—for assessing and improving the quality of managed care services offered by all managed care organizations (see 42 CFR §§ 438.202-210).

Types of State standards for care include: (1) a ratio of providers to beneficiaries, (2) a distance or travel-time maximum from the beneficiary to the provider, (3) an appointment wait-time maximum, or (4) another measure of access. Additionally, State standards for access to care may apply to specific provider types (e.g., primary care providers, specialty care providers), population types (e.g., children, long term care beneficiaries), or area types (e.g., rural, urban).

In the following questions, please describe ALL of your State's standards for access to care—according to each standard's type—that were in effect on January 1, 2012, as well as any new or changed standards that were in effect on January 1, 2013.

Provider-to-Population Ratio Standards

2.1. On **January 1, 2012**, did your State have any **provider-to-population ratio standard(s)** for access to care (e.g., 1 provider to 1000 beneficiaries)? If your State had separate provider-to-population ratio standards for different provider types, different population types, or urban and rural areas, check the box next to more than one standard and complete the questions below for each unique ratio.

- ☐ Yes, the State had **more than one** provider-to-population ratio standard in effect on January 1, 2012. → *Prompt questions (a) through (g) for each.*
- ☐ Yes, the State had **one** provider-to-population ratio standard in effect on January 1, 2012. → *Prompt questions (a) through (g) once.*
- ☐ No, the State did not have a provider-to-population ratio standard in effect on January 1, 2012. →Go to 2.2

a) Please describe this provider-to-population ratio standard as specifically as possible.

b) What does the **population portion** of this ratio include? Please specify whether it includes a population *in addition to* your State's Medicaid beneficiaries.

c) What does the **provider portion** of this ratio include? Please specify whether non-physician practitioners, such as physician assistants and nurse practitioners, are included.

d) What document contains this standard? In addition to the name of the document, please include the specific location of this standard within the document.

e) On what date was this standard adopted? (MM/DD/YY)

f) Has your State assessed whether MCOs meet this standard?

☐ Yes → Please describe how your State assessed whether MCOs met this standard, and describe how often your State assesses whether MCOs meet this standard.

☐ No

g) Is this standard still in effect?

☐ Yes → *Go to Question 2.2, once the questions above have been completed for all standards.*
☐ No → On what date was this standard terminated?

2.2 On **January 1, 2013**, did your State have any provider-to-population ratio standard(s) for access to care **different from or in addition to** the standard(s) described above?

☐ Yes → *Please complete questions (a) through (g) above for each new standard.*
☐ No

Distance or Travel-Time Standards

2.3 On **January 1, 2012**, did your State have any **distance or travel-time standard(s)** for access to care (e.g., 1 provider within 30 minutes or 30 miles of each beneficiary)? If your State had separate distance or travel-time standards for different provider types, different population types, or urban and rural areas, check the box next to more than one standard and complete the questions below for each unique standard.

☐ Yes, the State had **more than one** distance or travel-time standard in effect on January 1, 2012. → *Prompt questions (a) through (e) for each.*
☐ Yes, the State had **one** distance or travel-time standard in effect on January 1, 2012. → *Prompt questions (a) through (e) once.*
☐ No, the State did not have a distance or travel-time standard in effect on January 1, 2012. → *Go to Question 2.4.*

a) Please describe this distance or travel-time standard as specifically as possible.

b) What document contains this standard? In addition to the name of the document, please include the specific location of this standard within the document.

c) On what date was this standard adopted?

d) Has your State assessed whether MCOs meet this standard?

☐ Yes → Please describe how your State assessed whether MCOs met this standard, and describe how often your State assesses whether MCOs meet this standard.
☐ No

e) Is this standard still in effect?

☐ Yes → *Go to Question 2.4, once the questions above have been completed for <u>all</u> standards.*
☐ No → On what date was this standard terminated?

2.4 On **January 1, 2013**, did your State have any distance or travel-time standard(s) for access to care **different from or in addition to** the standard(s) described above?

☐ Yes → *Please complete questions (a) through (e) above for each new standard.*
☐ No

Appointment Wait-Time Standards

2.5 On **January 1, 2012**, did your State have any **appointment wait-time standard(s)** for access to care (e.g., appointment wait-time should not exceed 30 days for a routine appointment)? If your State had separate appointment wait-time standards for different provider types, different population types, or urban and rural areas, check the box next to more than one standard.

- ☐ Yes, the State had **more than one** appointment wait-time standard in effect on January 1, 2012. → *Prompt questions (a) through (e) for each.*
- ☐ Yes, the State had **one** appointment wait-time standard in effect on January 1, 2012. → *Prompt questions (a) through (e) once.*
- ☐ No, the State did not have a distance or travel-time standard in effect on January 1, 2012. → *Go to Question 2.6.*

a) Please describe this appointment wait-time standard as specifically as possible.

b) What document contains this standard? In addition to the name of the document, please include the specific location of this standard within the document.

c) On what date was this standard adopted?

d) Has your State assessed whether MCOs meet this standard?

- ☐ Yes → Please describe how your State assessed whether MCOs met this standard, and describe how often your State assesses whether MCOs meet this standard.
- ☐ No

e) Is this standard still in effect?

- ☐ Yes → *Go to Question 2.4, once the questions above have been completed for <u>all</u> standards.*
- ☐ No → On what date was this standard terminated?

2.6 On **January 1, 2013**, did your State have any appointment wait time standard(s) for access to care **different from or in addition to** the standard(s) described above?

- ☐ Yes → *Please complete questions (a) through (e) above for each new standard.*
- ☐ No

Additional Standards

2.7 On **January 1, 2012**, did your State have **any additional standards** for access to care that are not already described above?

- ☐ Yes, the State had **more than one** additional standard for access to care in effect on January 1, 2012. → *Prompt questions (a) through (e) for each.*
- ☐ Yes, the State had **one** additional standard for access to care in effect on January 1, 2012.→ *Prompt questions (a) through (e) once.*
- ☐ No, the State did not have any additional standards in effect on January 1, 2012. → *Go to Question 2.8.*

a) Please describe this additional standard as specifically as possible.

b) What document contains this additional standard? In addition to the name of the document, please include the specific location of this standard within the document?

c) On what date was this standard adopted?

d) Has your State assessed whether MCOs meet this standard?

☐ Yes → Please describe how your State assessed whether MCOs met this standard, and describe how often your State assesses whether MCOs meet this standard.
☐ No

e) Is this standard still in effect?

☐ Yes → *Go to Question 2.8, once the questions above have been completed for all standards.*
☐ No → On what date was this standard terminated?

2.8 On **January 1, 2013**, did your State have any additional standard(s) for access to care **different from or in addition to** the standard(s) described above?

☐ Yes → *Please complete questions (a) through (e) above for each new standard.*
☐ No

2.9 Please describe the process by which your State **originally** developed its standards for access to care.

a) What information did you review to develop your State's standards?

b) How often does your State reassess and/or revise these standards?

c) When was the last time your State reassessed and/or revised these standards?

d) Does your State have any plans to reassess and/or revise these standards in the future?

2.10 How often does your State conduct **external quality reviews (EQRs)** of each MCO in your State to determine compliance with standards pursuant to 42 CFR § 438.204(g)?

2.11 Please provide the publication date of your last EQR report for each MCO in your State that was selected for this evaluation (i.e., only those MCOs listed on page 2).

2.12 Did you require the MCO(s) to make any changes based on the most recent EQR(s)?

☐ Yes → Please describe as specifically as possible the changes you required the MCO(s) to make.
☐ No

2.13 In addition to the EQRs, does your State have in place other strategies to assess whether MCOs meet your State's standards for access to care? (For example, if your State conducts annual network reviews in addition to the EQRs, please check the box next to "Yes" and describe these reviews.)

☐ Yes → Please describe each strategy as specifically as possible.
☐ No

2.14 Between January 1, 2008 and January 1, 2013, did your State identify any of the MCOs selected for this evaluation as not meeting the State's standards for access to care?

☐ Yes→ Please provide the following information in the table below for each instance identified.
☐ No → *Go to Section 3.*

Approximate date that your State identified an MCO that was not meeting the State's standards for access to care	Name of this MCO	Please describe the standard that was not being met	Please describe how this MCO was not meeting this standard	Did your State take action against this MCO?	*IF YES TO PREVIOUS QUESTION:* What action(s) did your State take against this MCO?
MM/DD/YY				☐ Yes ☐ No	
MM/DD/YY				☐ Yes ☐ No	
MM/DD/YY				☐ Yes ☐ No	
MM/DD/YY				☐ Yes ☐ No	
MM/DD/YY				☐ Yes ☐ No	

Section 3: Medicaid Managed Care in your State

The previous questions asked specifically about your State's strategies for assessing whether MCOs meet State standards. The following question asks about your State's **broader monitoring and oversight efforts to ensure that Medicaid managed care beneficiaries in your State have access to care.**

3.1. Please describe your State's monitoring and oversight efforts for ensuring that **Medicaid managed care beneficiaries have access to care.** For example, if your State conducts patient satisfaction or secret shopper surveys to assess beneficiary access to care, include a description of those surveys here. Please be as specific as possible and include all State efforts to assess whether managed care beneficiaries have access to care.

3.2. Does your State anticipate having **a larger population of Medicaid managed care beneficiaries** in the future?

☐ Yes → *Prompt the following questions.*
☐ No → *Go to Section 4.*

a. Please describe the population(s) that will make up this larger number of Medicaid managed care beneficiaries.

b. What is your State's approximate timeline for expanding managed care to this/these population(s)?

c. Does your State have any plans for ensuring access to care for this larger number of Medicaid managed care beneficiaries?

☐ Yes → Please describe these plans as specifically as possible.
☐ No → *Go to Section 4.*

Section 4: Barriers to Access / Additional Comments

When answering the following questions, please consider both your State's strategies for ensuring that MCOs meet standards for access to care as well as any additional monitoring and oversight efforts your State may have.

4.1. Has your State **identified any barriers to access to care** for Medicaid managed care beneficiaries?

☐ Yes
☐ No → *Go to Question 4.2.*

a) Please describe the barriers that your State identified as specifically as possible.

b) Has your State taken any action to address these barriers?

☐ Yes → Please describe these actions as specifically as possible.
☐ No

4.2. Please provide any additional comments related to access to care under Medicaid managed care

Documentation Submission Checklist

Below is a checklist for ensuring that all necessary documents are submitted to OIG. Please email the following documents, as applicable, to Vincent.Greiber@oig.hhs.gov.

Document	Attached	Not Applicable
1. Documentation of your State's standards for access to care, pursuant to 42 CFR §§ 438.202-210, that have been referenced in this survey. Please indicate the location of the standards in each document. Only submit documentation of standards that are relevant to the MCOs selected for this evaluation. (See Question 2.1 through 2.6)	☐	
2. Documentation of any other standards your State may have related to access to managed care (e.g., waiver authority documentation, contracts with MCOs). Only submit documentation that is relevant to the MCOs selected for this evaluation. (See Questions 2.7 through 2.8)	☐	☐
3. Documentation of the strategies that your State has to assess whether the MCOs selected for this evaluation meet these standards for access to care, including external quality review (EQR) reports and other strategies. (See Questions 2.9 through 2.12)	☐	☐
4. Documentation of each instance between January 1, 2008 and January 1, 2013 in which your State identified any of the MCOs selected for this evaluation as not meeting the State's standards for access to care. For each instance, please include the name of the MCO, which standard was not being met, and how. (See Question 2.13)	☐	☐
5. Documentation of each action taken between January 1, 2008 and January 1, 2013 against any MCO selected for this evaluation that was identified as not meeting the State's standards for access to care. (See Question 2.13)	☐	☐
6. Documentation of your State's broader monitoring and oversight efforts for ensuring that Medicaid managed care beneficiaries have access to care. (See Question 3.1)	☐	☐

Contact Information

Please provide your contact information below.

Full Name: _____
Title: _____
Email Address: _____
Telephone #: _____

Thank you for your continued participation in OIG's Access to Medicaid Managed Care evaluation.

Brenda James

Log # 316

From: Beth Hutto
Sent: Wednesday, June 26, 2013 11:34 AM
To: Lauren Young; Brenda James
Subject: FW: OIG survey about collection and verification of Medicaid Provider Ownership

From: Kathleen Snider
Sent: Tuesday, June 04, 2013 6:17 PM
To: Janna.Sayer@oig.hhs.gov
Cc: Beth Hutto; Felicia Burkett; Nancy Sharpe
Subject: OIG survey about collection and verification of Medicaid Provider Ownership

I have just submitted the OIG survey for South Carolina regarding the Medicaid Provider Ownership. The related documents will be emailed as attachments to you within the next couple of days. Please don't hesitate to call me about our survey responses if you have any questions.

Kathleen C. Snider, Bureau Chief
Bureau of Compliance & Performance Review
South Carolina Department of Health and Human Services
P.O. Box 8206, 1801 Main Street
Columbia, SC 29202-8206
(803) 898-1050

INSTRUCTIONS TO APPLICANTS FOR MEDICAID PROVIDER ENROLLMENT REGARDING REQUIRED DISCLOSURES
Part 1

1. If you are an individual practitioner or in a group of practitioners that is not organized as a business proprietorship, limited liability corporation, partnership, or corporation, whether it be for profit or not for profit, you are not required to complete Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please indicate if you are enrolling only as an individual practitioner and are exempt from these disclosure requirements.

☐ **Yes** ☐ **No**

By answering "Yes", you are enrolling as an individual only and therefore exempt from disclosure requirements as required by Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514). Please complete all of Part 1. If "No" is checked, proceed to Part 2.

2. Provide the following information about yourself (individual practitioner only).
PLEASE NOTE: If you are not required to have a National Provider Identifier (NPI), please indicate "NA" in the NPI Field below.

*Full Name: First	M.I.	Last	Suffix	Title (MD, etc.)
*SSN:	*Date of Birth (mm/dd/ccyy): / /		*Gender:	
Provider Number: (If Known)	*NPI:	Email address:		
*Primary Practice Location Name and Address:		*Telephone Number:		
Name	Street Address	City	State	Zip + 4

Fields marked with an * must be completed.

3. Have you ever been convicted of a criminal offense in relation to Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP)? ☐ **Yes** ☐ **No**

If "Yes", list the charge(s), where convicted, the date, and disposition status of the conviction.
(Attach additional page(s) if necessary.)

Charge(s)	City/State of Conviction	Conviction Date	Disposition Status
		/ /	
		/ /	

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE IN MEDICAID, OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF THE AGREEMENT OR CONTRACT WITH the SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES (SCDHHS).

*Print or Type Full Name: _____

*Signature: _____ *Date: _____

Please send this page (Part 1) with your completed Medicaid enrollment application. Do not send Part 2 of the Disclosure form if you are exempt from Disclosure requirements. All other applicants for Medicaid enrollment must complete and submit only Part 2 of the Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514).

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT
PART 2

General Instructions

Federal Medicaid regulations (42 CFR 455.100 – .106) require that all Medicaid providers disclose the name, address, and other identifying information for each person with an ownership or control interest in the provider and any subcontractor in which the provider has a 5% or more interest. All applicants, except an individual practitioner or group of practitioners as defined in 42 CFR 455.101, must complete this form in order to enroll as a provider in the Medicaid program. The provider must also screen all employees and subcontractors to determine whether they have been excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) and/or all federal health care programs. Any individual or entity that employs or contracts with an excluded provider cannot claim reimbursement from Medicaid for any items or services furnished, authorized, or prescribed by the excluded provider.

Please answer all questions as of the **current date**. If the **"Yes"** block for an item is checked, list the requested additional information in the area provided; attach additional pages and/or documentation as needed, referencing the item number to which the information corresponds. Return the original to the South Carolina Department of Health and Human Services (SCDHHS); retain a copy for your files. Failure to provide this form and/or incomplete information will result in a refusal by SCDHHS to enter into an agreement or contract with any such provider or institution or in termination of existing agreements.

This form is to be completed for all programs established by Title XIX and Title XXI and **must be submitted within 35 days of any changes to provider information.** Completion and submission of this form is a condition of approval or renewal of a contract or agreement between the disclosing entity and SCDHHS. Any substantial delay in completing the form should be reported to SCDHHS.

Disclosure of Social Security Number (SSN): Disclosure of a SSN is used for the purpose of determining whether persons and entities named in an application are federally excluded parties and to verify licensure. **Refusal to provide a SSN will result in rejection of the provider's application to participate in the Medicaid program or termination of any existing provider agreement or contract.**

I. Instructions / Definitions: Providers that must have a National Provider Identifier (NPI) must include the NPI. If currently enrolled in South Carolina Medicaid with multiple NPI numbers, a separate Disclosure of Ownership and Control Interest Statement (SCDHHS Form 1514) must be completed for each NPI number.

I. Identifying Information			
[a] Name of Provider (Disclosing Entity): Doing Business As (trade or company name):			
Street Address		City, State, Zip + 4	
County	Provider Number(If Known)	NPI	Telephone Number
[b] Federal Employer Identification Number (FEIN):			

[c] Type of Entity (Applies to either For Profit or Non-Profit)

- ☐ Limited Liability Corporation (LLC)
- ☐ Partnership
- ☐ Corporation
- ☐ Business Proprietorship or Company
- ☐ Sole Proprietor
- ☐ Governmental Unit
- ☐ Other (Please specify)_____

II. Instructions / Definitions:

Providers must disclose ownership and control information as required by 42 CFR 455.101 - 104.
Ownership interest is defined as the possession of equity in the capital, the stock or the profits of the disclosing entity. ***A disclosing entity*** is a Medicaid provider (other than an individual practitioner or group of practitioners), or a fiscal agent.

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if A owns 10 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership and must be reported.

Control interest is defined as the direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e. joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Therefore, ***a person with an ownership or control interest*** is a ***person*** or ***corporation*** that –

(a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
(b) Has an indirect ownership interest totaling 5 percent or more in a disclosing entity;
(c) Has a combination of direct and indirect ownership interest equal to 5 percent or more in a disclosing entity;
(d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;
(e) Is an officer or director of a disclosing entity that is organized as a corporation; or
(f) Is a partner in a disclosing entity that is organized as a partnership.

Subcontractor means (a) an individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or, (b) an individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

II. Individuals and Organizations with Ownership or Control Interest

[a] List names, addresses, date of birth and SSN for individuals, or list names, addresses and the FEIN for organizations, having direct or indirect ownership or control interest, **as defined on pg. 2,** in the entity listed in Section I. Attach additional pages, if needed, for any additional names and addresses. **If Sole Proprietor or Business Proprietorship or company is checked in Section I, skip this section.**

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] Are any persons / entities with ownership or control interest in the provider also owners of other Medicare / Medicaid providers? If yes, list name of the owner from Section II [a] and the name and NPI and/or FEIN for each facility or SSN if an individual provider.

☐ Yes ☐ No

Name of Owner from Section II [a]	Name of Other Provider or Entity	NPI/SSN	FEIN

III. Subcontractors

[a] Please list any subcontractors of the disclosing entity (provider), **as defined on pg. 2,** in which the disclosing entity has a direct or indirect ownership of 5% or more.

☐ Not Applicable

Name of Subcontractor	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

[b] List the following information for individuals or organizations having direct or indirect ownership or a control interest, **as defined on pg. 2,** in any subcontractor in which the disclosing entity (provider) has a direct or indirect ownership of 5% or more. Attach additional pages, if needed, for additional names.

Name	Address	Date of Birth (If Individual)	SSN (If Individual)	FEIN

IV. Relationships

Are any of the individuals identified in Sections I, II or III related to each other? ☐ Yes ☐ No

If yes, list the individuals identified and the relationship to each other (spouse, sibling, parent, child, etc).

Name of Person 1	Name of Person 2	Relationship

V. Managing Employees

[a] List current managing employees as indicated below. "Managing employee" means general manager, office or business manager, administrator, director, or other individual who exercises operational or managerial control over the institution, agency, or organization, or who directly or indirectly conducts the day-to-day operations. Attach additional pages, if needed, for additional names.

Name/Title	Address	SSN	Date of Birth

[b] Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
☐ Yes ☐ No
If Yes, give date for change: Date / / . List names, titles, and SSN of the prior Administrator, Director of Nursing, or Medical Director.

Name	Title	SSN

VI. Management Company

A management company is defined as any organization that operates and manages a business on behalf of the owner of that business, with the owner retaining ultimate legal responsibility for operation of the facility. If the answer is yes, list the name of the management firm as well as the managing employees of the firm (i.e., CEO, CFO, etc). Attach additional pages, if needed, for additional names.

Is the provider/entity/facility operated by a management company?
☐ Yes ☐ No
If Yes, what is the term of the agreement?
Beginning Date / / to Ending Date / /

Name of Management Co.	Address	FEIN

Name(s) of Managing Employee(s)	SSN	Date of Birth

VII. Instructions / Definitions: Criminal Offenses related to the delivery of services or items under Medicare or Medicaid programs include convictions relating to patient neglect or abuse in connection with the delivery of a health care item or service; felony and/or misdemeanor convictions related to health care fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct; and felony and/or misdemeanor convictions related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

VII. Criminal Offenses

If any of the questions are answered "Yes", list names, addresses, and SSNs for individuals and names, addresses, and FEINs for organizations, or attach documentation or additional pages if needed.

[a] As listed in **Sections II or III**, have any individuals and organizations with a direct or indirect ownership of 5% or more in the disclosing entity (provider), or any subcontractor(s) in which the provider has a direct or indirect ownership of 5% or more, been convicted of a criminal offense related to the involvement of such persons or organizations in any of the programs established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)?

☐ Yes ☐ No

[b] As listed in **Sections V or VI,** have any directors, officers, agents, or managing employees of the disclosing entity (provider) ever been convicted of a criminal offense related to their involvement in such program established by Titles XVIII, XIX, or XXI (Medicare, Medicaid, or SCHIP)? ☐ Yes ☐ No

Name	Address	SSN/FEIN

VIII. Instructions / Definitions: Sanctions and other adverse actions include any revocation or suspension of a license to provide health care by any State licensing authority; any revocation or suspension of accreditation; and/or any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program.

VIII. Sanctions and Other Adverse Actions

Has your organization, under any current or former name or business identity, or any individuals and organizations listed in **Sections II, III, V, or VI,** ever had a final adverse action imposed against it? If yes, report the individual(s) or organization(s) involved, each final adverse action, when it occurred, and the Federal or State agency or the court/administrative body that imposed the action. ☐ Yes ☐ No

Individual/Organization	Adverse Action	Date	Taken by

IX. Instructions/ Definitions: Changes in provider status are defined as any change in management control. Examples of such changes would include: a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the ownership, including changes in any partnership arrangement, or any changes of ownership.

IX. Changes in Provider Status

If there has been a change in ownership /partnership within the last year or if you anticipate a change, indicate the date in the appropriate space. If there are no owners (i.e., the provider is a sole proprietorship), check Not Applicable.

[a] Has there been a change in ownership or controlling interest within the last year? If Yes, give date.
☐ Yes - Date: / / ☐ No ☐ Not Applicable

X. Instructions / Definitions: A chain affiliate is any free-standing health care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more free-standing health care facilities organized within or across State lines which is under the ownership or through any other devices, control and direction of a private, charitable or propriety. They also include subsidiary organizations and holding corporations. Provider-based facilities, such as hospital-based home health agencies, <u>are not</u> considered to be chain affiliates.

X. Chain Affiliation

[a]. Is this facility chain-affiliated? If Yes, list name, address and FEIN of parent Corporation below.
☐ Yes ☐ No

Name	Address	FEIN

[b]. If the answer to part [a] of this item was "No", was the facility ever affiliated with a chain? If Yes, list name, address and FEIN of parent Corporation.
☐ Yes ☐ No

Name	Address	FEIN

Certification Statement

You MUST sign and date the certification statement below in order to be enrolled in the Medicaid program. In doing so, you are attesting to meeting and maintaining the Medicaid requirements stated below.

I, the undersigned, certify to the following:

1. I have read the contents of this form, and the information contained herein is true, correct, and complete. If I become aware that any information listed on this form is not true, correct, or complete, I agree to notify Medicaid of this fact within thirty-five (35) days of discovery.

2. I authorize Medicaid to verify the information contained herein. I agree to notify Medicaid of a change in ownership, practice location and/or Final Adverse Action within 35 days of the reportable event. In addition, I agree to notify Medicaid of any other changes to the information on this form within 35 days of the effective date of change. I understand that any change in business structure of this provider may require the submission of a new application.

3. I understand that any deliberate omission, misrepresentation, or falsification of any information contained on this form or contained in any communication supplying information to Medicaid, or any deliberate alteration of any text on this form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicaid billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.

4. I agree to abide by the Medicaid laws, regulations and program instructions that apply to me or to the organization. The Medicaid laws, regulations, and program instructions are available through SCDHHS. I understand that payment of a claim by Medicaid is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions, and on the provider's compliance with all applicable conditions of participation in Medicaid.

5. Neither I, nor any managing employee listed on this form, is currently sanctioned, suspended, debarred, or excluded by the Medicare or State Health Care Program, e.g., Medicaid program, or any other Federal program, or is otherwise prohibited from providing services to Medicaid or other Federal program beneficiaries.

6. I agree that any existing or future overpayment made to me or to the organization(s) listed on this form, by the Medicaid program, may be recouped by Medicaid through the withholding of future payments.

7. I understand that the Medicaid identification number issued to me can only be used by me or by a provider to whom I have reassigned my benefits under current Medicaid regulations, when billing for services rendered by me.

8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

Name of Authorized Representative (Printed or Typed):	Title:
Signature:	Date:

1.1.19 Ownership Page Definition

Component Name	Provider Enrollment Ownership
Description	This page captures the type(s) of ownership that make up the provider's practice.
Navigation Map	Provider Services → Provider Enrollment → Individual/Atypical Individual/Ordering/Referring → Ownership
Target Users	Providers, Provider Office Staff, BCBSSC Provider Enrollment Operations staff
Notes	

Enrollment Type	Page Displayed	Page Completion Optional/Required
Individual	Yes	Required
Atypical Individual	Yes	Required
Ordering/Referring	Yes	Required
Organization	Yes	Required
Atypical Organization	Yes	Required
Add Location	Yes	Required

1.1.19.1 Ownership Page Layout

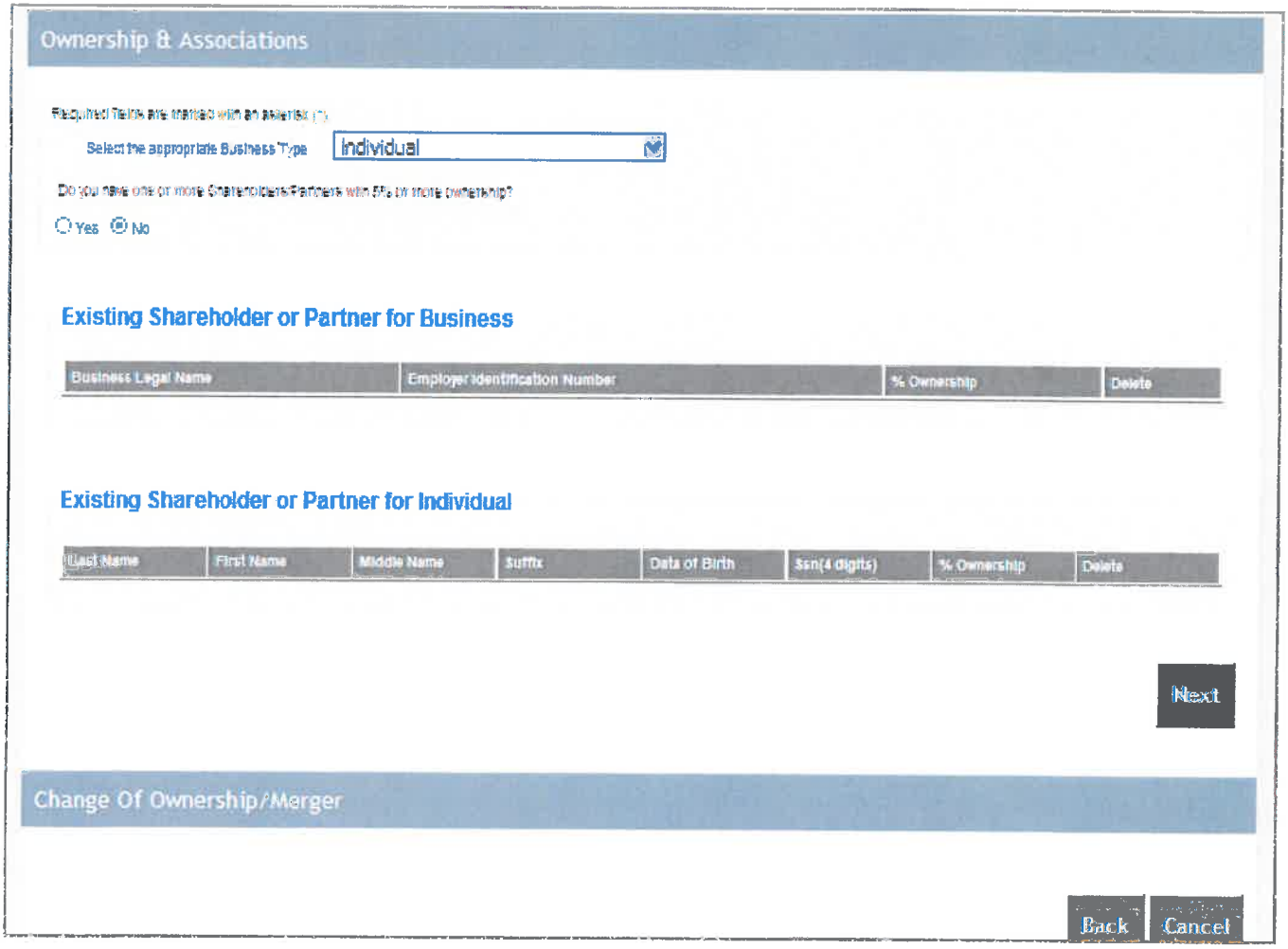


Figure 1. Ownership Page_No Partners/Shareholders

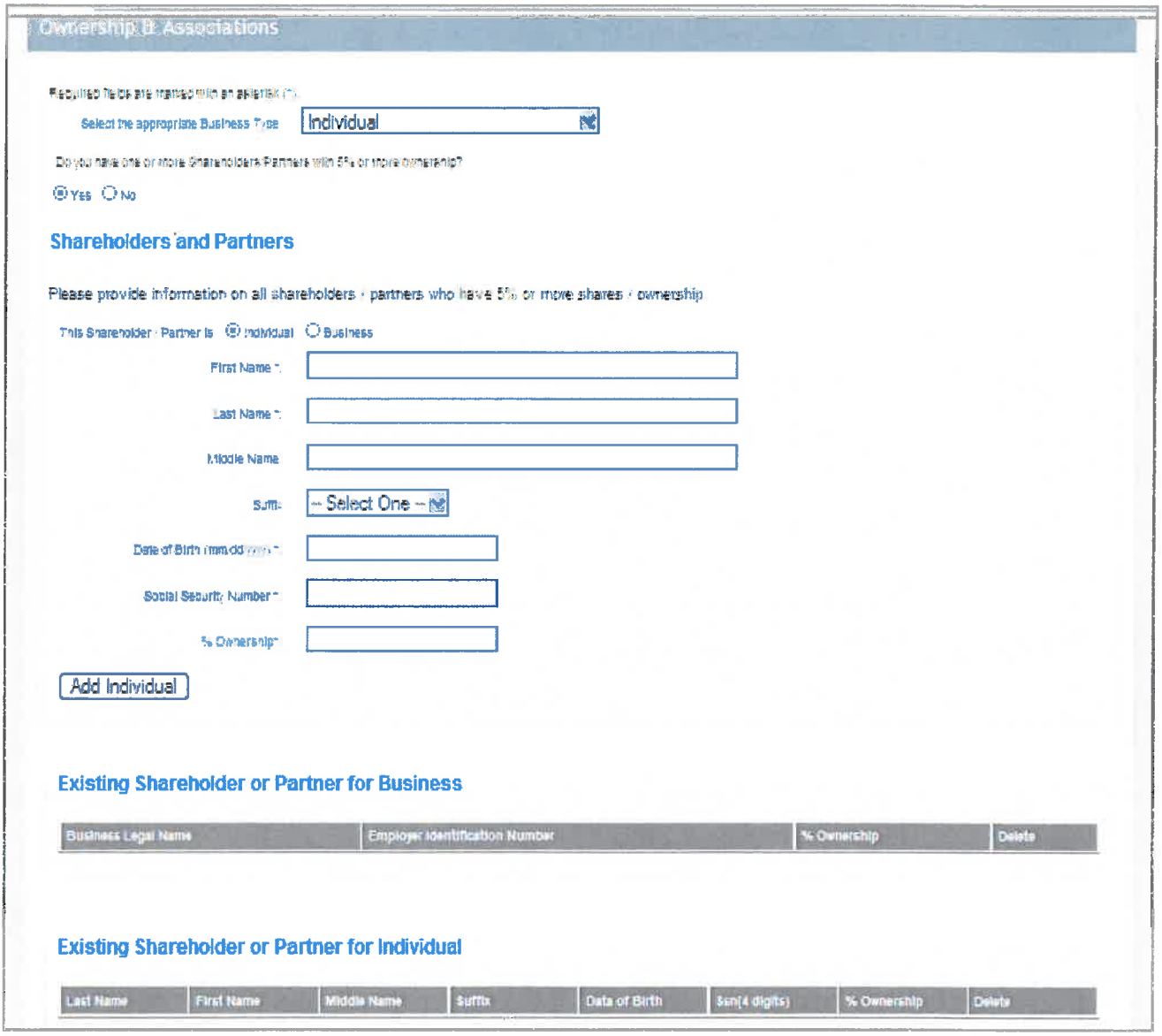


Figure 2. Ownership Page_Selection "Yes" for Individual Partners/Shareholders

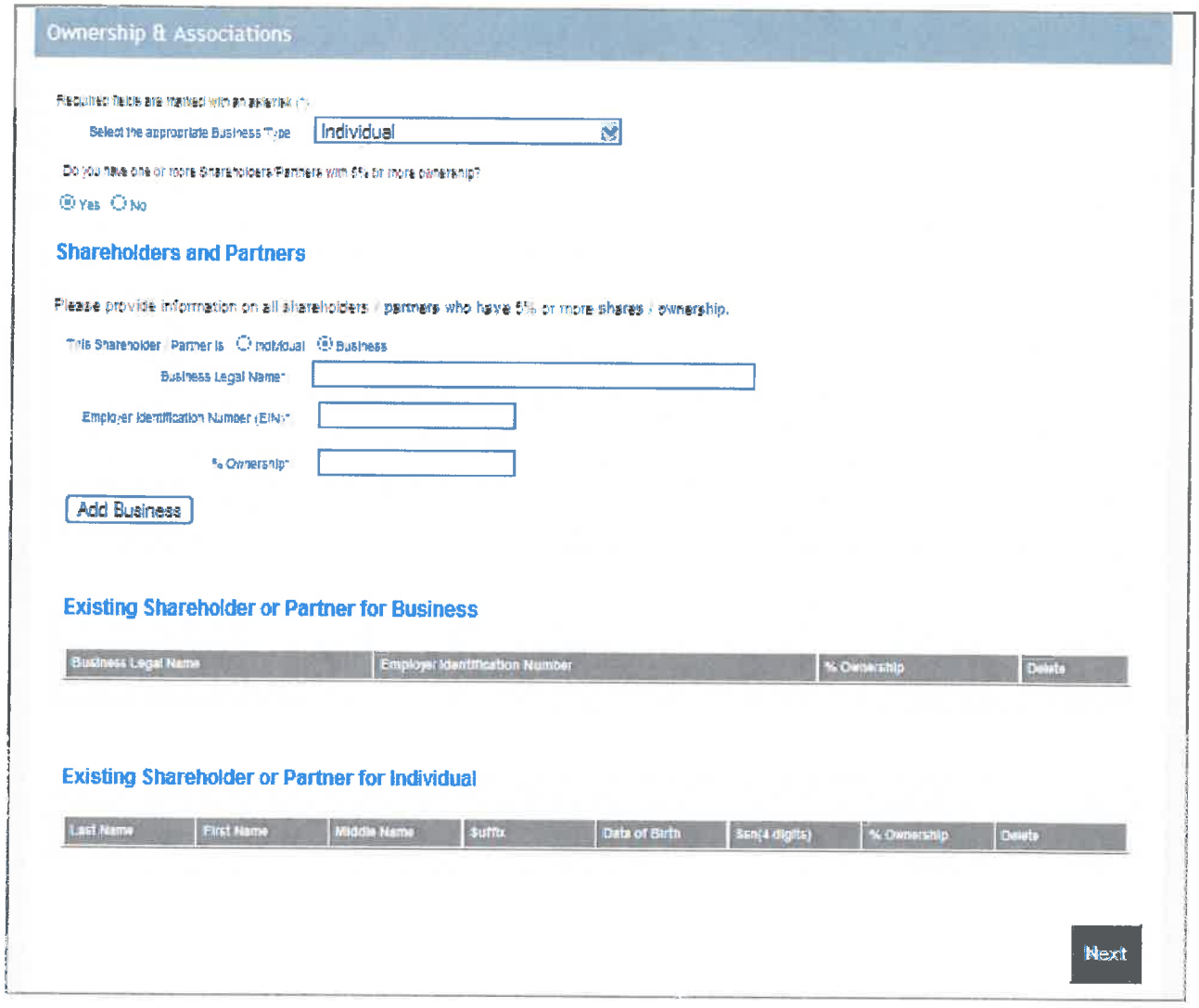


Figure 3. Ownership Page_Selection "Yes" for Business Partners/Shareholders

1.1.19.2 Ownership Page Specifications

Description/Label	Element Type	Req (A/C/N)	Protected (A/C/N)	Data Type	Max Size	Specifications
Select the appropriate Ownership Type*	Select Box	N	N	String	50	Valid Values: Refer to the Valid Values section of the BRD.
Do you have one or more Shareholders/Partners with 5% or more ownership:	Text	A	N	String	50	Yes or No Radio Button If the ownership type is any choice other than Sole Proprietor and Business Proprietorship and company show the Shareholders and Partners accordion.

Shareholders And Partners	Label	N/A	N/A	N/A	N/A	N/A
Please provide information on all shareholders/partners who have 5% or more shares/ownership.						
This Shareholder / Partner is	Radio Button	C	N	Boolean	1	Individual/Business Radio Button
Individual						If 'an individual' is selected, the following 7 fields are displayed.
First Name*	Text Box	C	N	String	50	Required Field. Display message # DM011, "This field is required." When data is not entered.
Last Name*	Text Box	C	N	String	50	Required Field. Display message # DM011, "This field is required." When data is not entered.
Middle Name	Text Box	N	N	String	50	
Suffix	Select Box	N	N	String	50	Valid Values: Please refer to the valid values section of the BRD.
Date of Birth*	Date Selector	C	N	Date	10	Required Field. Display message # DM011, "This field is required." When data is not entered.
Social Security Number*	Text Box	C	N	String	9	
% Ownership*	Text Box	A	N		5	Required field. Format is 3 places with two decimal places to accommodate a 1/3 percentage of ownership. Values must be greater than or equal to 5.00% but less than or equal to 100% (100.00) Display message #DM002, "Enter a value that is less than or equal to 100, when this condition is not met.
Familial Relationship to Enrolling Provider	Select Box	N	N	String	50	Valid Values: Please refer to the valid values section of the BRD.
Add Individual	Button	N/A	N/A	N/A	N/A	N/A

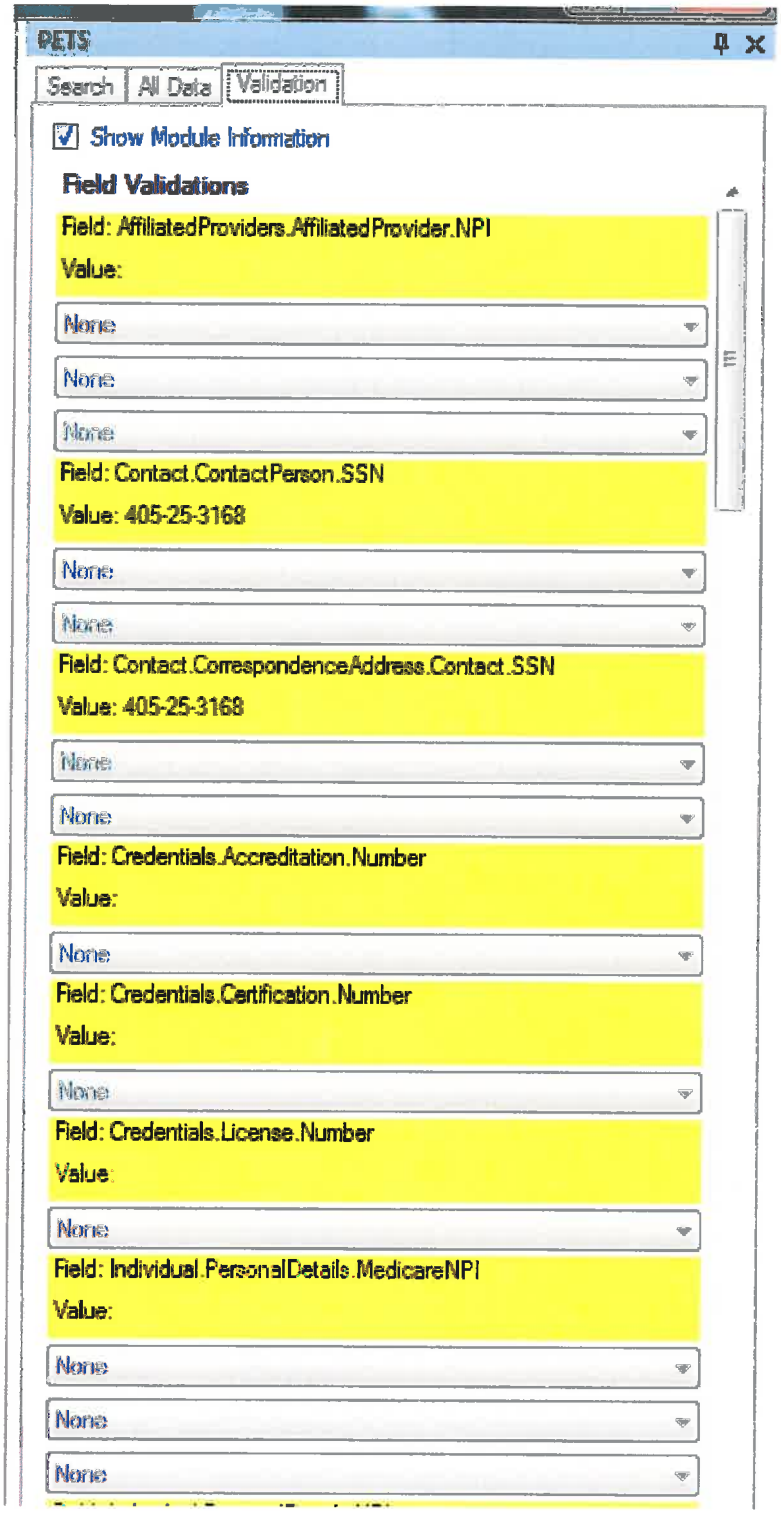
Business						If 'a business' is selected, the following 2 fields are displayed.
Business Legal Name*	Text Box	C	N	String	50	Required Field. Display message # DM011, "This field is required." When data is not entered.
Employer Identification Number (EIN)*	Text Box	C	N	String	9	Required Field. Display message # DM011, "This field is required." When data is not entered.
% Ownership*	Text Box	A	N		5	Required field. Format is 3 places with two decimal places to accommodate a 1/3 percentage of ownership. Values must be greater than or equal to 5.00% but less than or equal to 100% (100.00) Display message #DM002, "Enter a value that is less than or equal to 100, when this condition is not met.
Add Business	Button	NA	NA	NA	NA	NA
Back	Button	NA	NA	NA	NA	NA
Existing Shareholder or Partner for Business	Label	NA	NA	NA	NA	NA
Business Legal Name	Display	NA	NA	NA	NA	NA
EIN	Display	NA	NA	NA	NA	NA
% Ownership	Display	NA	NA	NA	NA	NA
Delete	Display	NA	NA	NA	NA	Button the user can select to delete the row entry
Existing Shareholder or Partner for	Label	NA	NA	NA	NA	NA
First Name	Display	NA	NA	NA	NA	NA
Last Name	Display	NA	NA	NA	NA	NA
Middle Name	Display	NA	NA	NA	NA	NA
Suffix	Display	NA	NA	NA	NA	NA
Date of Birth	Display	NA	NA	NA	NA	NA
SSN	Display	NA	NA	NA	NA	NA
Familial Relationship	Display	NA	NA	NA	NA	NA
% Ownership	Display	NA	NA	NA	NA	NA
Delete	Display	NA	NA	NA	NA	Button the user can select to delete the row entry
Next	Button	NA	NA	NA	NA	NA

Back	Button	NA	NA	NA	NA	The display message #, DM015," Important Enrollment Information"
Important Enrollment Information	Pop-up Message					All changes will be lost. Do you wish to continue? "
Cancel	Button	NA	NA	NA	NA	The display message #, DM015," Important Enrollment Information"
Important Enrollment Information	Pop-up Message					All changes will be lost. Do you wish to continue? "

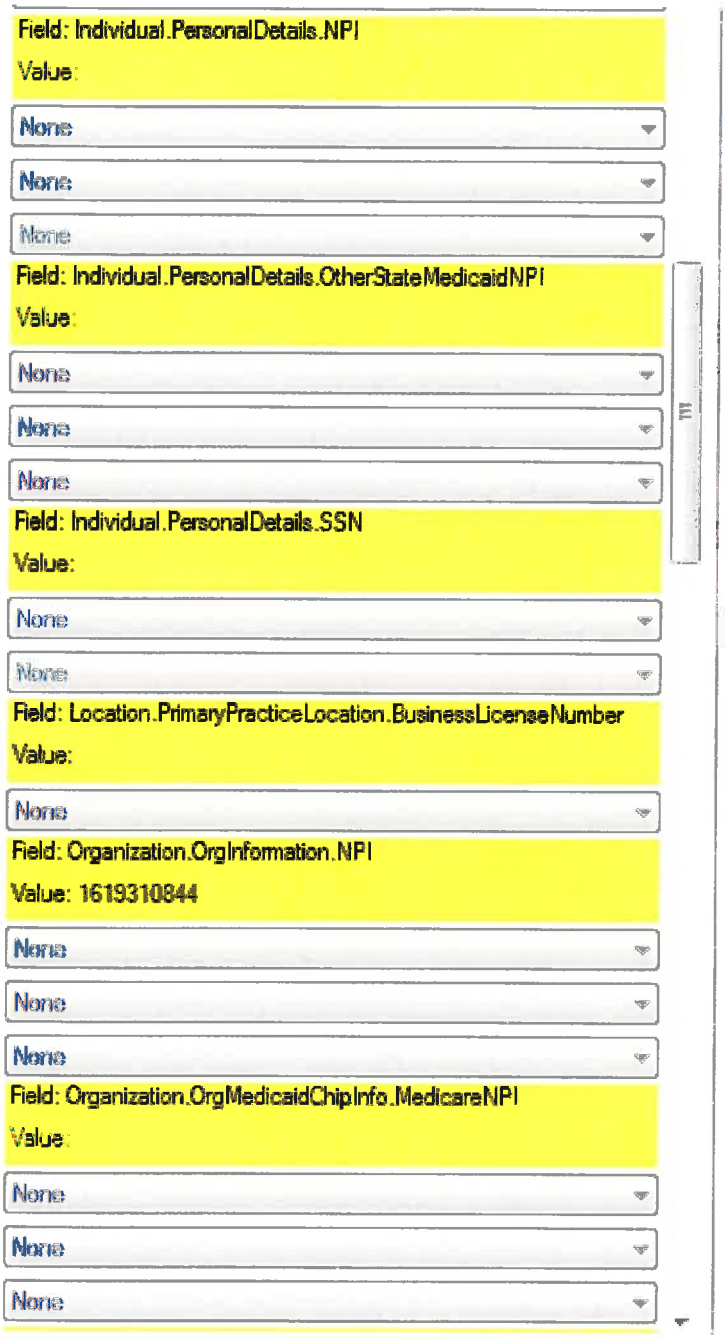
1.1.19.3 Ownership Page Actions

User Action	Type	Condition	Reaction
User clicks Next	Button		The next section of the accordion page is displayed to the user.
User clicks Back			The display message #DM015," Important Enrollment Information: All changes will be lost. Do you wish to continue? "
Important Enrollment Information	Pop-up Message		The User selects OK and the current page is closed without saving the changes and the prior page is displayed. The user selects Cancel, and the current page is displayed.
User Clicks Cancel	Button		The display message #DM015," Important Enrollment Information: All changes will be lost. Do you wish to continue? "
Important Enrollment Information	Pop-up Message		The User selects OK and the current page is closed without saving the changes and the previous page is displayed. The user selects Cancel, and the current page is displayed.

Provider Enrollment Tracking System Validations



Provider Enrollment Tracking System Validations



Field: Organization.OrgMedicaidChipInfo.OtherStateMedicaidNPI
Value:

None

None

None

Field: OwnershipDetails.ShareholderOrPartner.SSN
Value: 405-25-3168

None

None

Field: PhysicianPreceptors.PhysicianPreceptor.LicenseNumber
Value:

None

Field: PhysicianPreceptors.PhysicianPreceptor.NPI
Value:

None

None

None

Field: Relationships.Relationship.SSN
Value: 405-25-3168

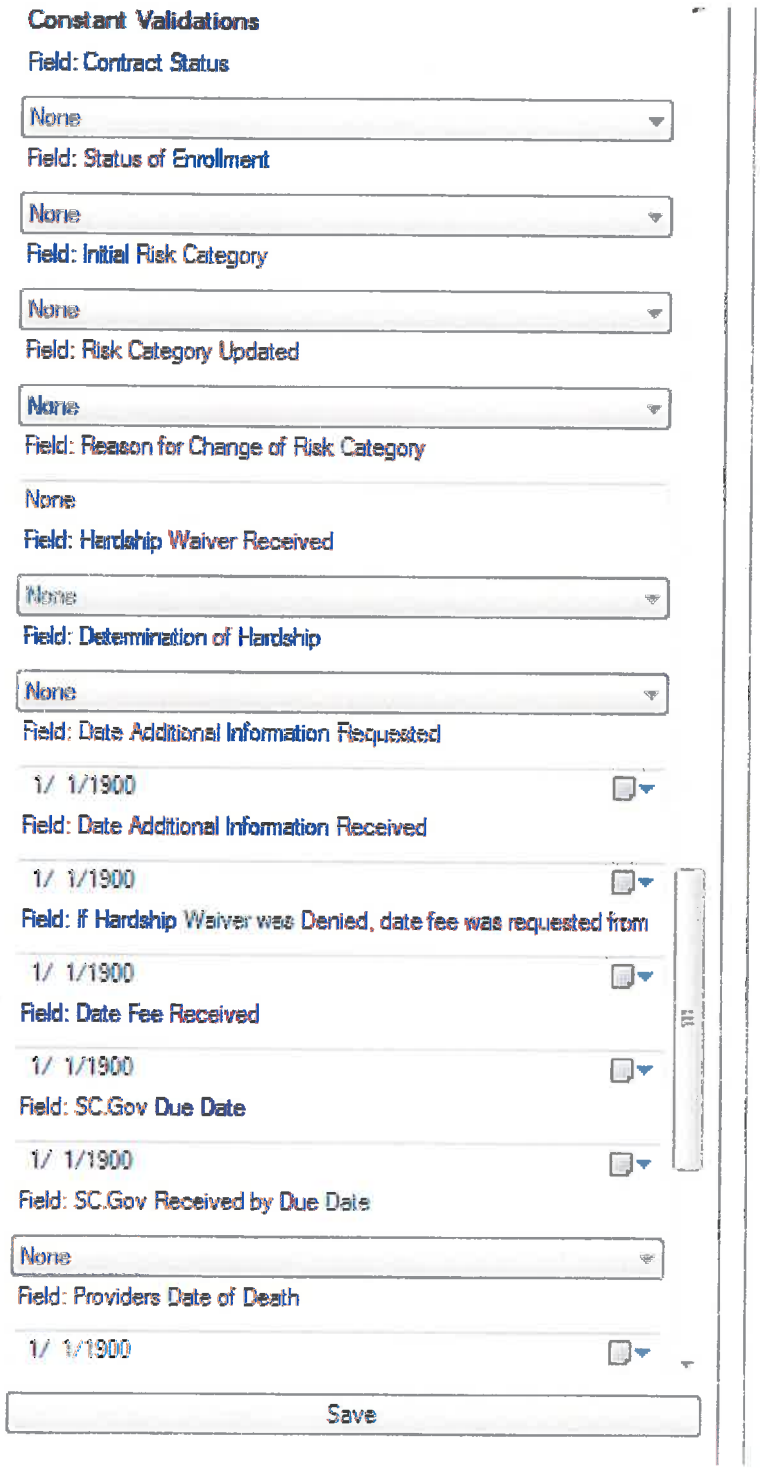
None

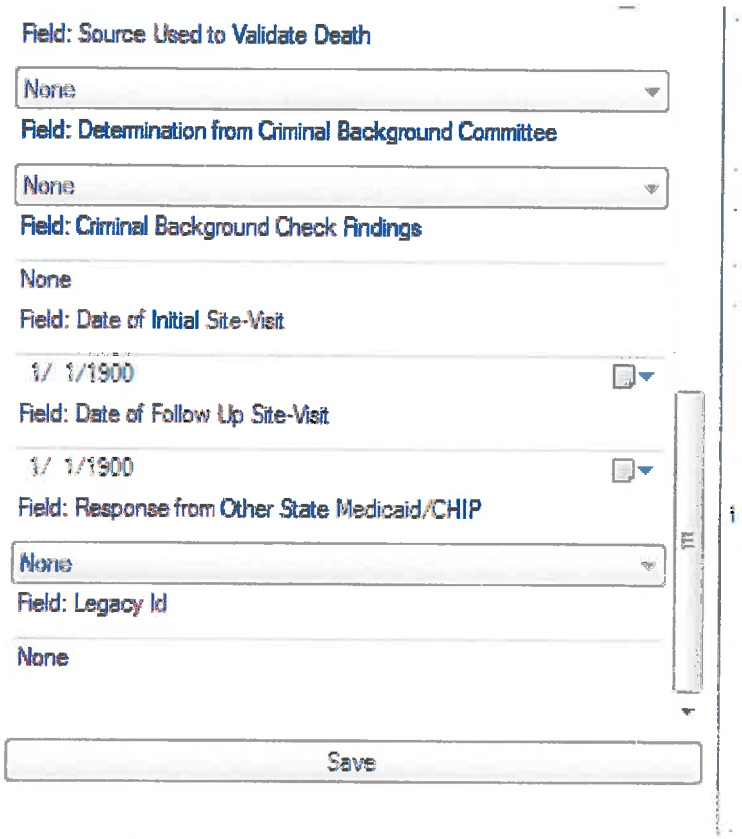
None

Field: Sanction.ConvictedIndividualSSN
Value:

None

None


Constant Validations
Field: Contract Status
None
Field: Status of Enrollment
None
Field: Initial Risk Category
None
Field: Risk Category Updated
None
Field: Reason for Change of Risk Category
None
Field: Hardship Waiver Received
None
Field: Determination of Hardship
None
Field: Date Additional Information Requested
1/ 1/1900
Field: Date Additional Information Received
1/ 1/1900
Field: If Hardship Waiver was Denied, date fee was requested from
1/ 1/1900
Field: Date Fee Received
1/ 1/1900
Field: SC.Gov Due Date
1/ 1/1900
Field: SC.Gov Received by Due Date
None
Field: Providers Date of Death
1/ 1/1900
Save


Field: Source Used to Validate Death
None
Field: Determination from Criminal Background Committee
None
Field: Criminal Background Check Findings
None
Field: Date of Initial Site-Visit
1/ 1/1900
Field: Date of Follow Up Site-Visit
1/ 1/1900
Field: Response from Other State Medicaid/CHIP
None
Field: Legacy Id
None
Save

PROVIDER ENROLLMENT

GENERAL DESK PROCEDURES

South Carolina

VERSION 2

JANUARY 2013

[redacted] *Individual (Typical/Atypical, Ordering/Referring) Enrollment Application*

1. Open the new enrollment application via the Initial Review step and applicable doctype in iFlow.
2. Determine the provider type, specialty, risk level, and contract status using the chart in the appendices of the desk procedures. Index the provider type and specialty, and add the risk level and contract status to the comments.
3. Check MMIS to confirm the provider is not currently enrolled
   a. If the provider is currently enrolled in Medicaid, transfer the application to the update Doctype and treat the new application as an update.
   b. If the provider record is in MMIS with an enroll status of 3 (involuntary termination), 4 (voluntary termination), active under a different provider type, or if the provider is not currently enrolled in South Carolina Medicaid, proceed with the screening process.
   c. If the provider record is in MMIS with an enroll status of 5 (suspended), or 6 (terminated for cause), contact Program Integrity for review before continuing the enrollment process. Add a comment and move the enrollment to the Program Integrity step.
4. Determine if the provider is enrolled in Medicare via PECOS using https://am.cms.hhs.gov/amserver/UI/Login?realm=legacy&goto=https%3A%2F%2Fpecosai.cms.hhs.gov%3A443%2Fpecosai%2Flogin.action.
   a. If the provider is not enrolled, IMT the screen to the application and proceed with screening.
   b. If the provider is enrolled, verify the provider has been enrolled or screened within the last 12 months. IMT the information into iFlow and attach to the enrollment application.
      - If yes, verify NPI and license, and check the SC Excluded Provider List and the Death Master File. Attach all documents and move the application to the Analyst Review step.
      - If no, proceed with screening.

3.2.1. *Limited Risk Screening*

The identity and exclusion status of all providers including medical professionals and any other eligible professional, any person with an ownership or control interest, and any agent or managing employee of the enrolling/enrolled provider must be screened against the following State/Federal databases upon enrollment, re-enrollment and revalidation:

1. MCSIS - https://csp.cms.hhs.gov
2. MED - https://MED.CMS.gov

If a Data Prep Tech sends provider information from a hit on LEIE/OIG, access and research the database. Send all findings to the assigned Data

Prep Tech. If the provider is on the SCDHHS Excluded Provider Listing, MCSIS, MED, or LEIE deny the provider. *(See Denial Procedures)*

3. SAM - www.SAM.gov
4. SCDHHS Excluded Provider Listing – http://www.scdhhs.gov/provider the fraud prevention and detection database for the state of South Carolina.
5. LEIE/OIG - http://www.exclusions.oig.hhs.gov/search.aspx, list of excluded individuals/entities owned by the U.S. Department of Health & Human Services Office of Inspector General (OIG). This is a fraud prevention and detection database.

   If exclusion data is found on LEIE/OIG, give the provider information to the Provider Enrollment manager. If the provider is on the SCDHHS Excluded Provider Listing, MCSIS, MED, or LEIE deny the provider. *(See Denial Procedures)*

6. Licensure – Use the appropriate State Medical Board website to verify the provider's license number and issue date. Frequently used State Medical Board websites include:

   - http://www.docboard.org/docfinder.html (AIM Docfinder). This website accesses medical boards for every state.
   - **https://verify.llronline.com/LicLookup/LookupMain.aspx** (South Carolina Medical Board)
   - http://wwwapps.ncmedboard.org/Clients/NCBOM/Public/LicenseeInformationSearch.aspx (North Carolina Medical Board)
   - http://services.georgia.gov/dch/mebs/jsp/index.jsp (Georgia Medical Board)
   - http://www.clearhq.org/Default.aspx?pageId=481835 (Council on Licensure, Enforcement and Regulation)
   - If the license cannot be verified, send the enrollment to the Analyst Review step. The Provider Analyst sends the provider an RTP via the enrollment database. The Data Prep Tech will IMT the letter and attach it to the enrollment information in iFlow. The RTP letter should indicate "You are currently not licensed/certified/permitted as required by Medicaid policy and procedures" as the reason. On the summary form in "Notes to Provider", the analyst may add specific license information. *(See Appendix F.)*

7. SSA-Death Master

   If the provider is on the SSA-Death Master file, send the enrollment to the Analyst Review step with comments. RTP the provider and ask for a copy of his/her social security card to be faxed/e-mailed to Medicaid.Enrollment@bcbssc.com . (See RTP Procedures.)

All providers, owners, applicants found to have a hit on any of the above checks must be reported in the PET database with the appropriate denial reason. MMIS and PET

database must be updated with appropriate reason. In addition, query the name against the database for additional hits.

If the provider is on the SCDHHS Excluded Provider Listing, MCSIS, MED, LEIE, send the enrollment to the Analyst Review step with comments. Deny the provider. *(See Denial Procedures)*

Each source, including website screens, must be IMTed to the Enrollment Form in iFlow, whether or not a name was found at the website.

1. NPPES - http://nppes.cms.hhs.gov, the National Plan and Provider Enumeration System, the National Provider Identifier (NPI) registry.

   If the NPI cannot be verified, the Provider Analyst sends the provider an RTP via the enrollment database. On the RTP letter, the analyst should indicate, "You are currently not licensed/certified/permitted as required by Medicaid policy and procedures" as the reason. On the summary form in "Notes to Provider", add "Your NPI could not be validated on NPPES".

3.2.2. *Moderate Risk Screening*

1. If the provider is moderate risk, follow steps outlined in 3.1 and 3.2.1. If not enrolled in OOS Medicaid or Medicare, fill out the form requesting the Provider Relations Reps to schedule the site visit. Suspend the application to the Site Visit step while the visit is being processed.
2. When the site visit is complete, contact GIS and request a Criminal History Background check on the provider, managing employees, and owners.
3. Check the CB Log for previously found hits. If none were found, suspend the application to the Criminal Background (CB) step while waiting for correspondence.
4. Once correspondence is returned, IMT the documentation to the enrollment application and suspend the application to the CB Committee (DHHS) step.
   a. If the provider is denied, send the denial letter *(See Denial Procedures)*
   b. Add approved conviction that prevents enrollment to the CB Log *(See CB Log Procedures.)*
   c. If the provider is approved, proceed with processing the enrollment.

3.2.3. *High Risk Screening*

1. If the provider is high risk, follow steps outlined in 3.1 and 3.2.1. If not enrolled in OOS Medicaid or Medicare, fill out the form requesting the Provider Relations Reps to schedule the site visit. Suspend the application to the Site Visit step while the visit is being processed.
2. When the site visit is complete, contact GIS and request a Criminal History Background check on the provider, managing employees, and owners.
3. Check the CB Log for previously found hits. If none were found, suspend the application to the Criminal Background (CB) step while waiting for correspondence.
4. Once correspondence is returned, IMT the documentation to the enrollment application and suspend the application to the CB Committee (DHHS) step.

a. If the provider is denied, send the denial letter via the denial procedures listed below.
b. Add approved conviction that prevents enrollment to the CB Log *(See CB Log Procedures)*
c. If the provider is approved, move the enrollment to the Analyst Review step and proceed with processing the enrollment.

Criminal History Background Checks with Fingerprinting is on hold pending additional federal guidance. Criminal History Background Checks with Fingerprinting will be implemented within 60 days of formal announcement.

3.2 Organization/Atypical Organization

1. Open the new enrollment application via the Initial Review step and applicable doc type in iFlow.
2. Determine the provider type, specialty, risk level, and contract status using the chart in the appendices of the desk procedures. Index the provider type and specialty, and add the risk level and contract status to the comments.
3. Check MMIS to confirm the provider is not currently enrolled
   a. If the provider is currently enrolled in Medicaid, transfer the application to the update Doctype and treat the new application as an update.
   b. If the provider record is in MMIS with an enroll status of 3 (involuntary termination), 4 (voluntary termination), active under a different provider type, or if the provider is not currently enrolled in South Carolina Medicaid, proceed with the screening process.
   c. If the provider record is in MMIS with an enroll status of 5 (suspended), or 6 (terminated for cause), contact Program Integrity for review before continuing the enrollment process. Add a comment and move the enrollment to the Program Integrity step.
4. Determine if the provider is enrolled in Medicare via the PECOS report using https://am.cms.hhs.gov/amserver/UI/Login?realm=legacy&goto=https%3A%2F%2Fpecosai.cms.hhs.gov%3A443%2Fpecosai%2Flogin.action.
   a. If the provider is not enrolled, IMT the screen to the application and check for out of state Medicaid enrollment and/or fee payment.
   b. If the provider is enrolled, verify the provider has been enrolled or screened within the last 12 months. IMT the information into iFlow and attach to the enrollment application.
      - If the provider was not enrolled or screened within the last 12 months no fee payment is needed. Continue with full screening.
      - If the provider was enrolled or screened within the last 12 months, check NPPES, IMT documentation, and move the application to the Analyst Review step.
4. If the provider is not listed in PECOS, determine if the provider is enrolled in another state's Medicaid/CHIP via the provider's enrollment application.

   If the provider checked "yes", contact the state and ask:

- Is/has the provider ever been enrolled in your state's Medicaid or CHIP?
- Is the provider in good standing?

Record the state's representative's contact information (i.e. name, number, address, and fax) and add results in comments of iFlow.

[redacted] First Level Screening

To begin first level screening, move the enrollment application back to the Initial Review step with comments and follow steps outlined in 3.2 and below.
The identity and exclusion status of all providers including medical professionals and any other eligible professional, any person with an ownership or control interest, and any agent or managing employee of the enrolling/enrolled provider must be screened against the following State/Federal databases upon enrollment, re-enrollment and revalidation:

1. MCSIS - https://csp.cms.hhs.gov
2. MED - https://MED.CMS.gov

   If a Data Prep Tech sends provider information from a hit on LEIE/OIG, access and research the database. Send all findings to the assigned Data Prep Tech. If the provider is on the SCDHHS Excluded Provider Listing, MCSIS, MED, or LEIE deny the provider. *(See Denial Procedures)*
3. SAM - www.SAM.gov
4. SCDHHS Excluded Provider Listing – http://www.scdhhs.gov/provider the fraud prevention and detection database for the state of South Carolina.
5. LEIE/OIG - http://www.exclusions.oig.hhs.gov/search.aspx, list of excluded individuals/entities owned by the U.S. Department of Health & Human Services Office of Inspector General (OIG). This is a fraud prevention and detection database.

   If exclusion data is found on LEIE/OIG, give the provider information to the Provider Enrollment manager. If the provider is on the SCDHHS Excluded Provider Listing, MCSIS, MED, or LEIE deny the provider. *(See Denial Procedures)*
6. Licensure – Use the appropriate State Medical Board website to verify the provider's license number and issue date. Frequently used State Medical Board websites include:
   - http://www.docboard.org/docfinder.html (AIM Docfinder). This website accesses medical boards for every state.
   - https://verify.llronline.com/LicLookup/LookupMain.aspx (South Carolina Medical Board)
   - http://wwwapps.ncmedboard.org/Clients/NCBOM/Public/LicenseeInformationSearch.aspx (North Carolina Medical Board)
   - http://services.georgia.gov/dch/mebs/jsp/index.jsp (Georgia Medical Board)

- http://www.clearhq.org/Default.aspx?pageId=481835 (Council on Licensure, Enforcement and Regulation)

If the license cannot be verified, the Provider Analyst sends the provider an RTP via the enrollment database. The Data Prep Tech will IMT the letter and attach it to the enrollment information in iFlow. The RTP letter should indicate "You are currently not licensed/certified/permitted as required by Medicaid policy and procedures" as the reason. On the summary form in "Notes to Provider", the analyst may add specific license information. *(See Appendix F.)*

7. SSA-Death Master

   If the provider is on the SSA-Death Master file, e-mail the provider and ask for a copy of his/her social security card to be faxed/e-mailed to Medicaid.Enrollment@bcbssc.com . (See RTP Procedures.)

All providers, owners, applicants found to have a hit on any of the above checks must be reported in the Provider Enrollment (PE) database with the appropriate denial reason. MMIS and PE database must be updated with appropriate reason. In addition, query the name against the database for additional hits.

If the provider is on the SCDHHS Excluded Provider Listing, MCSIS, MED, LEIE, deny the provider. *(See Denial Procedures)*

Each source, including website screens, must be IMTed to the Enrollment Form in iFlow, whether or not a name was found at the website.

1. NPPES - http://nppes.cms.hhs.gov, the National Plan and Provider Enumeration System, the National Provider Identifier (NPI) registry.

   If the NPI cannot be verified, the Provider Analyst sends the provider an RTP via the enrollment database. The Data Prep Tech will IMT the letter and attach it to the enrollment information in iFlow. On the RTP letter, the analyst should indicate, "You are currently not licensed/certified/permitted as required by Medicaid policy and procedures" as the reason. On the summary form in "Notes to Provider", add "Your NPI could not be validated on NPPES".

3.2.4. *Moderate Risk Screening*

1. If the provider is moderate risk, and not enrolled in OOS Medicaid or Medicare, move the enrollment application back to the Analyst Review step. Follow steps outlined in 3.2, 3.2.3 and below. The analyst will fill out the form requesting Provider Relations Rep to schedule the site visit. Suspend the application to the Site Visit step while the visit is being processed.
2. When the site visit is complete, contact GIS and request a Criminal History Background check on the provider, managing employees, and owners.
3. Check the CB Log for previously found hits. If none were found, suspend the application to the Criminal Background (CB) step while waiting for correspondence.
4. Once correspondence is returned, IMT the documentation to the enrollment application and suspend the application to the CB Committee (DHHS) step.
   a. If the provider is denied, send the denial letter via the denial procedures listed below.

b. Add approved conviction that prevents enrollment to the CB Log *(See CB Log Procedures)*

c. If the provider is approved, proceed with processing the enrollment.

3.2.5. *High Risk Screening*

1. If the provider is moderate risk, and not enrolled in OOS Medicaid or Medicare, move the enrollment application back to the Analyst Review step. Follow steps outlined in 3.2, 3.2.3 and below. The analyst will fill out the form requesting the Provider Relations Reps to schedule the site visit. Suspend the application to the Site Visit step while the visit is being processed.
2. When the site visit is complete, contact GIS and request a Criminal History Background check on the provider, managing employees, and owners.
3. Check the CB Log for previously found hits. If none were found, suspend the application to the Criminal Background (CB) step while waiting for correspondence.
4. Once correspondence is returned, IMT the documentation to the enrollment application and suspend the application to the CB Committee (DHHS) step.
   a. If the provider is denied, send the denial letter via the denial procedures listed below.
   b. Add approved conviction that prevents enrollment to the CB Log *(See CB Log Procedures)*
   c. If the provider is approved, proceed with processing the enrollment.

Criminal History Background Checks with Fingerprinting is on hold pending additional federal guidance. Criminal History Background Checks with Fingerprinting will be implemented within 60 days of formal announcement.

Brenda James

Log # 316

From: Beth Hutto
Sent: Wednesday, May 22, 2013 4:28 PM
To: Brenda James
Subject: RE: Office of Inspector General Evaluations of State Medicaid Programs

So, the due date is COB June 7.

Thanks,

Beth

From: Brenda James
Sent: Wednesday, May 22, 2013 11:14 AM
To: Beth Hutto; Lauren Young; Mike Cannon
Cc: Janet Bell; Bruce Harbaugh; Deirdra Singleton; Jan Polatty; Jean Maner
Subject: RE: Office of Inspector General Evaluations of State Medicaid Programs
Importance: High

Thanks so much, I will change the date in the Exec log system. Issue has been resolved.....thanks everyone. ☺ bj

Brenda G. James
Administrative Assistant
Office of the Director
SC Department of Health and Human Services
Columbia, SC 29201
jamesbr@scdhhs.gov
(803) 898-2580
Fax: (803) 255-8235

From: Beth Hutto
Sent: Wednesday, May 22, 2013 10:53 AM
To: Brenda James; Lauren Young; Mike Cannon
Cc: Janet Bell; Bruce Harbaugh; Deirdra Singleton; Jan Polatty
Subject: RE: Office of Inspector General Evaluations of State Medicaid Programs

Brenda,

I explained the delay to CMS and they gave us an additional 2.5 weeks to complete. We are working on that now and will get it done prior to the new deadline. Thanks,

Beth

From: Brenda James
Sent: Wednesday, May 22, 2013 10:50 AM
To: Lauren Young; Beth Hutto; Mike Cannon
Cc: Janet Bell; Bruce Harbaugh; Deirdra Singleton; Jan Polatty
Subject: RE: Office of Inspector General Evaluations of State Medicaid Programs
Importance: High

Good morning All,

I have not spoken to Mike regarding this log and it was not relogged. Didn't know it needed to be relogged because no one mentioned it. OOPS ☹!!!!! The only person I have heard from is Janet Bell w/Bruce Harbaugh's response, which is attached. Please let me know who the second half goes to. Due date was April 17, 2013, a month overdue. Thanks, bj

Brenda G. James
Administrative Assistant
Office of the Director
SC Department of Health and Human Services
Columbia, SC 29201
jamesbr@scdhhs.gov
(803) 898-2580
Fax: (803) 255-8235

From: Lauren Young
Sent: Wednesday, May 22, 2013 8:36 AM
To: Beth Hutto; Brenda James; Mike Cannon
Subject: RE: Office of Inspector General Evaluations of State Medicaid Programs

This log was assigned to managed care and admin services (Mike) per Deirdra. Per Mike, this did not fall under his area and he couldn't answer the questions that were being asked in the survey. Mike reported back to Brenda and the log was supposed to be relogged.

Brenda—Did you ever relog this... Log letter 000316? Or did Deirdra make any other suggestions on who should complete the second half of this survey?

Thanks

From: Beth Hutto
Sent: Tuesday, May 21, 2013 5:39 PM

To: Lauren Young
Subject: FW: Office of Inspector General Evaluations of State Medicaid Programs

Lauren,

I ended up with this survey being assigned to me. According to Bruce, it was assigned to Roy and I when it came in. I had not heard of it until yesterday. Can you check on why we did not receive it? Maybe I did and missed it but want to make sure.

Can you also calendar the due date? Talked to OIG and they are giving us until 6/7 to complete. Kathy Snider, Felicia Burkett, and Nancy Sharpe are working on this too. Thanks,

Beth

From: Bruce Harbaugh
Sent: Monday, May 20, 2013 11:09 AM
To: Sayer, Janna (OIG/OEI)
Cc: Beth Hutto
Subject: RE: Office of Inspector General Evaluations of State Medicaid Programs

Janna

I have checked with our Director's office and the second survey from the Office of Inspector General Evaluations of Stats Medicaid programs on the Survey for State Agencies' collection and verification of provider ownership information was assigned to Beth Hutto. Beth's e-mail address is Huttob@scdhhs.gov and her phone number is 803-898-2031. I have cc'd her on this response to you.

From: Sayer, Janna (OIG/OEI) [mailto:Janna.Sayer@oig.hhs.gov]
Sent: Monday, May 20, 2013 10:41 AM
To: Bruce Harbaugh
Subject: FW: Office of Inspector General Evaluations of State Medicaid Programs

From: Sayer, Janna (OIG/OEI)
Sent: Monday, May 20, 2013 9:55 AM
To: 'harbaugh@sc.rr.com'; 'info@scdhhs.gov'
Subject: RE: Office of Inspector General Evaluations of State Medicaid Programs

Hello. I am writing to follow-up on the status of South Carolina's Medicaid Provider Ownership survey that is outstanding. The extended deadlines have passed, and we have not received communication from your state. Please be in touch.

Best,

Janna Sayer

Janna F. Sayer, MPH
Program Analyst
U.S. Department of Health and Human Services
Office of Inspector General
Office of Evaluation and Inspections
61 Forsyth Street, SW, Suite 3B80
Atlanta, GA 30303
P (404) 562-7738
F (404) 562-2994

From: Greiber, Vincent W (OIG/OEI)
Sent: Tuesday, April 02, 2013 3:17 PM
To: info@scdhhs.gov
Cc: Davis, Hailey E (OIG/OEI); Sayer, Janna (OIG/OEI)
Subject: Office of Inspector General Evaluations of State Medicaid Programs

Dear Mr. Keck,

Thank you for your continued participation in the Office of Inspector General evaluations of State Medicaid programs. Attached is a request for your participation in two online surveys related to the two ongoing evaluations: (1) State agencies' collection and verification of provider ownership information, and (2) State standards for access to care for Medicaid managed care beneficiaries. Please use the following instructions to login to complete these two online surveys before **April 19, 2013.**

Instructions:

1. **State agencies' collection and verification of provider ownership information**

   To access this survey, click the following link:

   https://surveys.oig.hhs.gov/snapwebhost/surveylogin.asp?k=136379943696

   In the STATE ABBREVIATION field enter your State's two-letter abbreviation in capital letters (**SC**); you will not need to enter a password to complete this survey. You may find it helpful to have available state laws and regulations and department policies and procedures relevant to the provider ownership disclosure requirements (42 CFR § 455.104). Throughout the survey, we will ask for these documents to be emailed.

   If you have any questions about this survey, please contact Janna Sayer, Program Analyst, at Janna.Sayer@oig.hhs.gov or 1-800-334-4878.

2. **Access to providers enrolled in Medicaid managed care plans**

   To access this survey, click the following link:

   https://surveys.oig.hhs.gov/snapwebhost/surveylogin.asp?k=136484261154

   In the USERNAME field enter your State's two-letter abbreviation in capital letters (**SC**); you will not need to enter a password to complete this survey. Also attached is a reference copy of the survey questions, which includes the list of managed care organizations that we have selected for this evaluation. You may find it helpful to have available the following documents as you complete the survey; we will ask you to submit these documents at the end of the survey:

   1. Documentation of your State's standards for access to care, pursuant to 42 CFR §§ 438.202-210.
   2. Documentation of any other standards your State may have related to access to managed care.

3. Documentation of the strategies that your State has to assess whether MCOs in your State meet these standards for access to care, including external quality review (EQR) reports and other strategies.

4. Documentation of each instance between January 1, 2008 and January 1, 2013 in which your State identified an MCO that was not meeting the State's standards for access to care, if applicable.

5. Documentation of each action taken between January 1, 2008 and January 1, 2013 against an MCO that was not meeting the State's standards for access to care, if applicable.

6. Documentation of your State's broader efforts to ensure that beneficiaries enrolled in Medicaid managed care have access to care.

If you have any questions about this survey, please contact me at Vincent.Greiber@oig.hhs.gov or call me at (212) 264-5034.

Thank you again,

Vince

Vincent Greiber
Program Analyst
Office of Inspector General
Department of Health and Human Services
26 Federal Plaza, 41-106
New York, NY 10278

Brenda James

Log # 316

From: Roy Hess
Sent: Tuesday, May 07, 2013 5:34 PM
To: Brenda James
Subject: FW: Draft OIG Survey (log Letter 316)

FYI Log Letter 316

From: Bruce Harbaugh
Sent: Tuesday, May 07, 2013 4:00 PM
To: Janet Bell
Cc: Annmarie McCanne; Roy Hess
Subject: RE: Draft OIG Survey (log Letter 316)

The survey has been successfully submitted. We have some difficulty as the website was no longer viewable. I was able to speak with Vince Greiber with OIG and he assisted me in getting access to the website.

From: Janet Bell
Sent: Wednesday, May 01, 2013 9:23 AM
To: Bruce Harbaugh
Cc: Janet Bell
Subject: RE: Draft OIG Survey (log Letter 316)

Bruce,
I know you've been busy with the move but any update here?
Janet

From: Janet Bell
Sent: Monday, April 29, 2013 8:26 AM
To: Bruce Harbaugh
Cc: 'Janet Bell (BELLJ@scdhhs.gov)'
Subject: RE: Draft OIG Survey (log Letter 316)

Please let me know when you submit so I can close it out with Brenda. Thanks!

From: Roy Hess
Sent: Monday, April 29, 2013 8:03 AM
To: Bruce Harbaugh
Cc: Jennifer Campbell; Janet Bell
Subject: Draft OIG Survey (log Letter 316)

Looks good!! Thanks!

From: Bruce Harbaugh
Sent: Friday, April 19, 2013 5:20 PM
To: Janet Bell; Roy Hess; Jennifer Campbell
Subject: Draft OIG Survey (log Letter 316)

Roy

Attached is the draft of responses for log Letter 316 (OIG Survey). The survey is an online survey and I have attached a PDF copy. The printed pages do not show all of the language in the responses so I am also attaching a document that will show all of the language in the responses for areas identified as attachments. The survey can be viewed online at https://surveys.oig.hhs.gov/snapwebhost/surveylogin.asp?K=136379943696. The sign on is SC (in caps) and no password need to be entered.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Outsourcing Medicaid Administrative Functions Outside the U.S.

CONTACT SHEET

Please complete and return to Marcia Wong
via fax 415.437.7920 or email Marcia.Wong@oig.hhs.gov
by May 9, 2013.

State	South Carolina
Contact for OIG Survey:	
First and Last Name	Vicki Johnson
Position/Title	Assistant General Counsel
Agency/Division	S C Department of Health and Human Services
Direct Telephone Line	803-898-2648
Email	johnvic@scdhhs.gov
Fax Number	803-255-8210
Mailing Address	P.O. Box 8206 1801 Main Street Columbia, SC 29202-8206

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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CONTACT SHEET

Please complete and return to Marcia Wong
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First and Last Name	Vicki Johnson
Position/Title	Assistant General Counsel
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Direct Telephone Line	803-898-2648
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Fax Number	803-255-8210
Mailing Address	P.O. Box 8206 1801 Main Street Columbia, SC 29202-8206

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Hutto	4-26-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000338	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ cc: Keck	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

April 24, 2013

MAILED CERTIFIED

Lexington County DHHS
Attn: Lynelle E. Price
605 W. Main Street
Lexington, SC 29072-2503

Re: Sarah Frye
Medicaid#: 0781445311

Dear Ms. Price:

I previously sent a the following letter certified on April 2, 2013 which was received April 3, 2013. As of this date I have received no response. I am trying to make sure the State of South Carolina is reimbursed and I am quite surprised that the State is not interested in collecting this money.

Prior letter sent: April 2, 2013

Please be advised that I was in an automobile accident on December 1, 2012. Please see attached information so you may submit Medicaid's lien for reimbursement.

Insurance Company: Access Insurance Company
Address: P.O. Box 105143, Atlanta, GA 30348-5143
Phone Number: 1-866-747-6931 Fax Number: 1-866-347-2110
Claim Number: ASI0010964

The following are my medical expenses that Medicaid paid due to the accident.

12-01-2012	Lexington County EMS	$607.00
12-01-2012	Lexington Medical Center	$1120.00
12-02-2012	Lexington Medical Center (OB exam)	$370.00
TOTAL		$2097

I respectfully request that this lien be submitted as soon as possible as the insurance company is ready to settle. Please forward a copy of the lien to me and Access Insurance.

Sincerely

Sarah Frye
241 White Knoll Road
West Columbia, SC 29170

CC: ~~Sara Granger, SCDHHS State Director~~ Anthony Keck, Medicaid Director

Sarah Frye
241 White Knoll Road
W Columbia, SC 29170

COLUMBIA SC 290
25 APR 2013 PM 2 L

State Medicaid Director
Anthony Keck, Medicaid Director
South Carolina Department of Health & Human Services
P.O. Box 8206
Columbia, SC 29202

29202820606