

**PROVIDER MANUAL SUPPLEMENT
MANAGED CARE**

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MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Managed Care is a health care delivery model implemented by SCDHHS to establish a medical home for all Medicaid Managed Care eligible beneficiaries. The goals of a medical home include:

- Provide accessible, comprehensive, family-centered coordinated care
- Manage the beneficiary's health care, perform primary and preventive care services, and arrange for any additional needed care
- Provide beneficiaries access to a "live voice" 24 hours a day, 7 days a week, to ensure access to appropriate care
- Provide beneficiary education about preventive and primary health care, utilization of the medical home, and the appropriate use of the emergency room

The Division of Care Management administers the program for Medicaid beneficiaries by contracting with Managed Care Organizations (MCOs) and Care Services Organizations (CSOs) to offer health care services. CSOs support the Medical Homes Network (MHN) managed care health delivery model.

Managed care is not a new concept. Managed care has been a preferred health care delivery model in the private sector for decades. Enrolling in a managed care plan does not limit benefits, in fact, quite the opposite. All health plans offer, at a minimum, the same benefits offered under fee-for-service (FFS) Medicaid. In addition, all health plans offer enhanced benefits not available under the FFS Medicaid delivery model. These enhanced services may vary from plan to plan according to the contracted terms and conditions between SCDHHS and the managed care contractor.

Examples of enhanced benefits include:

- 24-hour nurse advice line
- Care coordination
- Health management programs (asthma, diabetes, pregnancy, etc.)
- No copayments
- Unlimited office visits
- Adult dental services

Providers, both in and out of network, should contact the MCO or the MHN Primary Care Physician (PCP) directly for assistance with benefits or prior authorization (PA) requirements before administering services to Medicaid-eligible beneficiaries enrolled in a managed care plan. **Providers should also check Medicaid eligibility and MCO or MHN enrollment prior to each authorization or delivery of services.**

The **Exhibits** section of this supplement provides contact information for MCOs and MHNs currently participating in the South Carolina Medicaid Managed Care program. Managed Care MCOs and MHNs are subject to change at any time. Providers are encouraged to visit the

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SCDHHS Web site (<http://www.scdhhs.gov>) for the most current listing of health plans, the counties in which they are authorized to operate, and the number of managed care enrollees within a county.

This Managed Care supplement is intended to provide an overview of the Managed Care program. Providers should review the MCO and MHN Policy and Procedure Guides for detailed program-specific requirements. Both guides are located on the SCDHHS Web site (<http://www.scdhhs.gov>) within the Managed Care section.

SC MEDICAID MANAGED CARE CONTACT INFORMATION

For additional information, contact the Division of Care Management at the following address:

South Carolina Department of Health and Human Services
Division of Care Management
Post Office Box 8206
Columbia, SC 29202-8206
Phone: (803) 898-4614
Fax: (803) 255-8232

PROGRAM DESCRIPTIONS

Managed Care Organizations (MCOs)

A Managed Care Organization (MCO) is commonly referred to as an HMO (Health Maintenance Organization) in the private sector. MCOs are required to operate under a contract with SCDHHS to provide health care services to beneficiaries through a network of health care professionals, both primary and specialty care, as well as hospitals, pharmacies, etc. Primary care providers (PCP) must be accessible within a 30-mile radius, while specialty care providers, to include hospitals, must be accessible within a 50-mile radius. While MCOs will contract with providers within a specific county, enrolled members may seek treatment, or be referred to in-network providers in neighboring counties.

MCOs are responsible for providing core services to Medicaid-eligible individuals as specified in their contract with SCDHHS. The health care providers within the MCO network are not required to accept FFS Medicaid as most claims are filed to and processed by the MCO. Only services rendered on a FFS basis require providers be enrolled in SC Medicaid, as those claims are paid by SCDHHS. (Core services are discussed further in the **Core Benefits** section of this supplement.)

SCDHHS currently uses two contracts with MCOs: a “standard contract” and an “ethical contract”. All MCOs, with the exception of First Choice by Select Health, operate under the standard contract. First Choice by Select Health is owned by a Catholic organization and operates under the ethical contract.

An MCO must receive a Certificate of Authority from the SC Department of Insurance and must be licensed as a domestic insurer by the State to render Medicaid managed care services.

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SCDHHS performs a rigorous approval process for each managed care entity. A complete guide to the approval process is available on the SCDHHS Web site. MCO model contracts used by the Managed Care program are approved by the Centers for Medicare and Medicaid (CMS).

This section of the supplement only reflects the general Medicaid policies and procedures that govern Managed Care Organizations in South Carolina. A complete guide to the Medicaid MCO Managed Care program can be found on the SCDHHS Web site under *Benefits Plan > MC Information > Managed Care Organization (MCOs) > MCO Policy and Procedures Guide*. The guide will be referred to as the MCO Policy and Procedures Guide throughout this document.

MCOs currently approved by SCDHHS are listed in the **Exhibits** section of this supplement and on the SCDHHS Web site (<http://www.scdhhs.gov>).

Core Benefits

Managed Care Organizations are fully capitated plans that provide a core benefit package similar to the current FFS Medicaid plan. MCO plans are required to provide beneficiaries with “medically necessary” care at current limitations for all contracted services. Unless otherwise specified, service limitations are based on the State fiscal year (July 1 through June 30). While appropriate and necessary care must be provided, MCOs are not bound by the current variety of service settings. For example, a service may only be covered FFS when performed in an inpatient hospital setting, while the MCO may authorize the same service to be performed both in an inpatient and an outpatient hospital setting.

MCOs may offer SCDHHS-approved expanded benefits. These are benefits that go beyond the core package. Additions, deletions, or modifications to the expanded benefits made during the contract year must be approved by SCDHHS. These expanded benefits may include medical services which are currently non-covered by FFS and/or which are above current Medicaid limitations.

Providers should refer to the **Core Benefits** section of the MCO Policy and Procedures Guide on the SCDHHS Web site (<http://www.scdhhs.gov>) for a detailed explanation of core benefits and service limitations.

Services Outside of the Core Benefits

The South Carolina Medicaid program continues to provide and/or reimburse certain fee-for-service benefits. Providers rendering services that are not included in the MCO’s benefits package, but are covered under FFS Medicaid receive payment in accordance with the current Medicaid fee schedule. These services are filed to SC Medicaid for processing and payment. MCOs are responsible for the beneficiaries’ continuity of care by ensuring appropriate referrals and linkages to the Medicaid FFS providers. For specifics concerning services outside of the core benefits, please see the MCO Policy and Procedures Guide on <http://www.scdhhs.gov>.

MCO Program Identification (ID) Card

The Managed Care Organization shall issue an identification card to the beneficiary within 14 calendar days of the selection of a primary care provider, or the date of receipt of the beneficiary’s enrollment data from SCDHHS, whichever is later.

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To ensure immediate access to services, the provider shall accept the beneficiary's Medicaid ID card as proof of enrollment in their plan until the beneficiary receives his or her MCO ID card. However, providers must always verify eligibility and confirm participation in a managed care plan on the same day the service is being rendered.

The MCO ID card must include at least the following information:

- The MCO name
- The 24-hour telephone number for the beneficiary to use in urgent or emergency situations and to obtain any additional information
- The name of the primary care physician
- The beneficiary's name and Medicaid ID number
- The MCO's plan expiration date (optional)
- The Member Services toll-free telephone number

Claims Filing

Providers should file claims with the MCO for beneficiaries participating in a managed care program, unless the service rendered is not covered by the MCO and is, instead, paid on a FFS basis by SC Medicaid. Providers should contact the MCO for managed care billing requirements. Non-contracted providers treating beneficiaries should contact the MCO for billing requirements prior to rendering services for authorization to provide treatment as an out-of-network provider. An exception is services rendered in an emergency room. Even if the physician is not in-network with the MCO, the MCO cannot refuse to reimburse for covered emergency services. Specifics concerning emergency coverage are contained in Section 4, **Emergency Medical Services**, of the MCO contract.

Prior Authorizations and Referrals

Providers should contact the beneficiary's MCO for prior authorization requests. Services provided to Medicaid beneficiaries enrolled in an MCO may require prior authorization from the MCO, with the exception of services provided in a hospital emergency department. Each MCO may have different prior authorization requirements. Admission to a hospital through the emergency department **may** require authorization. Hospitals should always check with the beneficiary's MCO plan for their requirements. The physician component for inpatient services **always** requires prior authorization. Specialist referrals for follow-up care after a hospital discharge also require prior authorization.

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Medical Homes Networks (MHNs)

Medical Homes Networks (MHNs) are Medicaid's Primary Care Case Management (PCCM) programs that link beneficiaries with a primary care provider (PCP). An MHN is a group of physicians who have agreed to serve as PCCM providers. They work in partnership with the beneficiary to provide and arrange for most of the beneficiary's health care needs, including authorizing services provided by other health care providers. They also partner with a Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for beneficiaries and for managing beneficiaries' care. The CSO supports the physicians and enrolled beneficiaries by providing care coordination, disease management, and data management. All providers participating in an MHN must be enrolled SC Medicaid providers, as all services are paid on a fee-for-service (FFS) basis.

The outcomes of the medical home initiative are a healthier, better educated Medicaid beneficiary, and cost savings for South Carolina through a reduction of acute medical care and disease-related conditions. The MHN provides case managers, who assist in developing, implementing, and evaluating the predetermined care management strategies of the network.

MHNs are under contract with the CSO, who, in turn, contract with SCDHHS. Providers must be in good financial standing with SCDHHS. MHN contracts with SCDHHS must receive CMS approval. A sample of an MHN contract can be reviewed on the SCDHHS Web site, under *Benefits Plans > MC Information > Medical Homes Networks Program (MHN) > Sample MHN Contract*.

This section of the supplement only reflects the general Medicaid policies and procedures that govern Medical Homes Networks in South Carolina. The complete guide to the Medicaid MHN Managed Care program can be found on the SCDHHS Web site (<http://www.scdhhs.gov>). The guide will be referred to as the MHN Policy and Procedures Guide throughout this document.

The MHN is responsible for the following components and services:

- Formal Care Coordination and Case Management
- Service Utilization Management
- Beneficiary Education
- Disease Management
- Provider Education and Training
- Pharmacy Management (including, but not limited to, Benefit Management Oversight and Clinical Risk Identification)

A listing of the current Medical Homes Networks operating in South Carolina is provided in the **Exhibits** section of this supplement, or providers may contact the Division of Care Management at (803) 898-4614.

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Core Benefits

Services provided under the MHN program are all paid on a FFS basis. As such, all claims are submitted to and processed by SCDHHS. Benefits offered in the MHN program mirror those offered in FFS with the following exceptions:

- All beneficiaries, regardless of age, receive unlimited ambulatory visits
- No copayment effective April 1, 2008

For additional information concerning core services and limitations, please refer to the MHN Policy and Procedures manual, or provider manuals for the applicable area (Physicians, Hospitals, etc.)

Prior Authorizations and Referrals

The PCP is contractually required to either provide medically necessary services or authorize another provider to treat the beneficiary via a referral. Even if a physician in the same practice, but at a different practice location with a different Medicaid “pay-to or group” Provider ID, treats a beneficiary, the services rendered still need a referral from the PCP. If a beneficiary has failed to establish a medical record with the PCP, the CSO, in conjunction with the PCP, shall arrange for the prior authorization (PA) on any existing referral. For a list of services that do not require authorization, refer to the **Exempt Services** section later in this supplement.

In some cases, the PCP may choose to authorize a service retroactively. All authorizations and consultations, including services authorized retroactively, are at the discretion of the PCP. The process for referring a beneficiary to a specialist can be made by telephone or in writing. The referral should include the number of visits being authorized and the extent of the diagnostic evaluation.

A PCP may authorize multiple visits for a specific course of treatment or a particular diagnosis. This prevents a provider to whom the beneficiary was referred from having to obtain a referral number for each visit so long as the course of treatment or diagnosis has not changed. The provider simply files the claims referencing the same referral number. It is the PCP’s responsibility to authorize additional referrals for any further diagnosis, evaluation, or treatment not identified in the scope of the original referral. If a specialist needs to refer the beneficiary to a second specialist for the same diagnosis, the beneficiary’s PCP must be contacted for a referral number.

A referral number is not required for services provided in a hospital emergency department or for an admission to a hospital through the emergency department. However, the physician component for inpatient hospital services does require a referral number. The hospital should contact the PCP for a referral number within 48 hours of the beneficiary’s admission. Specialist referrals for follow-up care after discharge from a hospital also require a referral from the PCP. In addition to the MHN’s authorization, prior approval may be required by SCDHHS to verify medical necessity before rendering some services. Prior authorizations are for medical approval only. Obtaining a prior authorization does not guarantee payment or ensure the beneficiary’s eligibility on the date of service.

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For a list of services requiring a referral number from the PCP, along with noted exceptions, please refer to the MHN Policy and Procedures Guide. Claims submitted for reimbursement must include the PCP's referral number.

Specific services sponsored by state agencies require a referral from that agency's case manager. The state agency's case manager should coordinate with the PCP and the MHN Care Coordinator to ensure the continuity of care. These services include, but are not limited to, the following:

- Audiologist Services
- High/Moderate Management Group Homes Services
- Occupational Therapist Services
- Physical Therapist Services
- Psychologist Services
- Speech Therapist Services
- Therapeutic Foster Care Services

Referrals for a Second Opinion

PCPs are required to refer a beneficiary for a second opinion at his or her request when surgery is recommended.

Referral Documentation

All referrals must be documented in the beneficiary's medical record. The CSO and the PCP shall review the monthly referral data to ensure that services rendered to the beneficiary were authorized and recorded accurately in the medical record. It is the PCP's responsibility to review the referral data for validity and accuracy, and to report inappropriate and/or unauthorized referrals to the CSO. The CSO is responsible for investigating these incidents and notifying SCDHHS if Medicaid fraud or abuse is suspected.

Exempt Services

Beneficiaries can obtain the following services from Medicaid MHN providers without obtaining a prior authorization from their PCP:

- Ambulance Services
- Dental Services
- Dialysis/End Stage Renal Disease Services
- Emergency Room Services (billed by the hospital)
- Family Planning Services
- Home- and Community-Based Waiver Services
- Independent Laboratory and X-ray ¹ Services
- Medical Transportation Services

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- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services
- State Agency Services²
- Speech and Hearing Clinic Services

¹ FQHCs/RHCs that provide laboratory and x-ray services under a separate provider number (not the FQHC/RHC number) must enter a prior authorization number on the claim form or the claim will be rejected.

² Agencies exempt from prior authorization are the Department of Mental Health, the Continuum of Care, the Department of Alcohol and Other Drug Abuse, the Department of Disabilities and Special Needs, the Department of Juvenile Justice, and the Department of Social Services.

The above list is not all-inclusive. For a complete list of exempt services, refer to the MHN Policy and Procedures Guide on the SCDHHS Web site (<http://www.scdhhs.gov>). Some services still require a prescription or a physician's order. Physicians should refer to the appropriate Medicaid Provider Manual for more detailed information and/or requirements, or contact their program manager.

Primary Care Provider Requirements

The primary care provider is required to either provide services or authorize another provider to treat the beneficiary. The following Medicaid provider types may enroll as a primary care provider:

- Family Medicine
- General Practitioners
- Pediatricians
- Internal Medicine
- Obstetrics and Gynecology
- Federally Qualified Health Centers (FQHCs)
- Rural Health Clinics (RHCs)

24-Hour Coverage Requirements

The MHN requires PCPs to provide access to medical advice and care for enrolled beneficiaries 24 hours per day, 7 days per week. A qualified medical practitioner must provide medical advice, consultation, and/or authorization or referral for services when appropriate within one hour of the beneficiary presentation or notification. PCPs must have at least one telephone line that is answered by office staff members during regular office hours.

MANAGED CARE SUPPLEMENT**MANAGED CARE OVERVIEW***Women, Infants, and Children (WIC) Program Referrals*

Federal law mandates coordination between Medicaid Managed Care programs and the WIC program. PCPs are required to refer potentially eligible beneficiaries to the local WIC program agency. The beneficiary must sign a WIC Referral Form and a Medical Records Release Form. Both forms are submitted to the local WIC agency for follow up.

For more information, providers should contact the local WIC agency at their county health department.

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MANAGED CARE SUPPLEMENT

MANAGED CARE ELIGIBILITY

Individuals must apply for SC Medicaid as outlined in Section 1 of this manual. If the applicant meets the established eligibility requirements, he or she may be eligible for participation in the Managed Care program. Not all Medicaid beneficiaries are eligible to participate in the Managed Care program.

The following Medicaid beneficiaries are **not eligible** to participate in a **Managed Care Organization**:

- Dually eligible beneficiaries (Medicare and Medicaid)
- Beneficiaries age 65 or older
- Residents of a nursing home
- Participants in limited benefits programs such as Family Planning Waiver, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Home- and Community-Based Waiver participants
- Medically Complex Children's Waiver Program participants
- Hospice participants
- Beneficiaries covered by an MCO/HMO through third-party coverage
- Beneficiaries enrolled in another Medicaid managed care plan

The following Medicaid beneficiaries are **not eligible** to participate in a **Medical Homes Network**:

- Medically Complex Children's Waiver Program participants
- Individuals institutionalized in a public facility
- Participants in limited benefits programs such as Family Planning Waiver, Specified Low Income Beneficiaries, Emergency Services Only, etc.
- Beneficiaries enrolled in another Medicaid managed care program
- Beneficiaries covered by an MCO/HMO through third-party coverage

MCOs issue an identification card to eligible beneficiaries that contain phone numbers to assist both beneficiaries and providers with benefits, health plan eligibility, and authorization questions specific to the managed care plan. The MCO card also contains the name of the beneficiary's primary care provider, as well as his or her health plan Member ID. **A beneficiary must present both the South Carolina Healthy Connections Medicaid ID card and the MCO-issued card before receiving services.**

MHNs do not issue additional identification cards to eligible beneficiaries. The South Carolina Healthy Connections Medicaid ID card serves as both their SC Medicaid card and their MHN card.

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Providers should verify beneficiaries' eligibility through the Web Tool, a point-of-service (POS) terminal, or the Interactive Voice Response System (IVRS) prior to delivering services. When verifying coverage via the IVRS, the Managed Care program information is given at the end of the inquiry.

MANAGED CARE SUPPLEMENT

MANAGED CARE ENROLLMENT

OVERVIEW

All managed care enrollment and disenrollment activities are handled through one single point of contact, South Carolina Healthy Connections Choices (SCHCC). SCHCC is responsible for processing the enrollment and disenrollment of Medicaid-eligible beneficiaries into a Managed Care plan. Beneficiaries may enroll online, by telephone, by mail, or by fax. The total Managed Care enrollment per full-time physician is limited to 2500 members, unless otherwise approved by SCDHHS.

Eligible SC Medicaid beneficiaries are encouraged to actively enroll with a Managed Care plan. Upon contacting SCHCC, Medicaid beneficiaries may currently select among the following Medicaid service delivery options:

- Managed Care Organization
- Medical Homes Network
- Fee-for-Service

SCHCC may be reached by calling (877) 552-4642, or via the SCHCC Web site: <http://www.SCchoices.com>. SCHCC should be contacted for assistance with enrollment, as well as transferring to, or disenrolling from, a health plan regardless of whether the beneficiary is in his or her 90-day choice period or lock-in period.

Not all Medicaid beneficiaries are eligible to participate in managed care. Beneficiaries who are eligible for participation are made aware of their eligibility via an outreach or enrollment mailing from SCHCC. An **enrollment packet** is mailed to beneficiaries who are required to make a plan choice. An **outreach packet** is mailed to beneficiaries who are eligible to participate in a managed care plan, but are not required to choose.

Beneficiaries receiving an enrollment packet are given at least 30 days to choose a plan. If the beneficiary does not choose a Managed Care plan within the allotted timeframe, the beneficiary is assigned to a Managed Care plan through SCHCC. (See **Enrollment Counselor Services** later in this supplement.)

Outreach and assignment is based on the beneficiary's payment category or Recipient Special Program (RSP) indicator, and is effective according to the published cut-off schedule.

If a Medicaid beneficiary enrolled in a managed care plan loses Medicaid eligibility, but regains it within 60-days, he or she will be automatically reassigned to the same plan and will forego a new 90-day choice period.

Beneficiaries cannot enroll directly with the MCO or the MHN. Beneficiaries must contact SCHCC to enroll in a Managed Care plan, or to change or discontinue their plan. A member can only change or disenroll without cause within the first 90 days of enrollment. If the beneficiary is approved to enroll in a Managed Care plan, or changes his or her plan, and is entered into the system before the established cut-off date, the beneficiary appears on the plan's member listing for the next month. If the beneficiary is approved, and entered into the system after the

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established cut-off date, the beneficiary will appear on the plan's member listing for the following month.

ENROLLMENT PROCESS

Medicaid beneficiaries receive a managed care enrollment packet or an outreach packet by mail within two days of first becoming eligible for Medicaid, or 30 to 60 days prior to their annual Medicaid review. Beneficiaries enrolled in a managed care plan will also receive a reminder letter from their health plan prior to their annual review date.

Beneficiaries are always encouraged to respond to SCHCC's efforts so that plan assignment does not result. While enrollment is encouraged during annual review, FFS Medicaid beneficiaries may contact SCHCC to enroll at anytime. They do not need to wait to receive enrollment information. Beneficiaries enrolled in a managed care plan at the time of their annual review will remain in their health plan unless they contact SCHCC during their open enrollment (90-day choice period) to request a change.

When enrollment packets are mailed, beneficiaries have at least 30 days from the mail date to choose a health plan, to include an MCO, an MHN, or FFS. If a beneficiary fails to act on the initial enrollment packet, reminder letters and postcards are mailed and outbound calls are placed in an effort to encourage plan selection. **A minimum of five attempts is made to reach all beneficiaries.** If, after the multiple outreach efforts, a beneficiary still fails to respond, he or she will be assigned to a managed care plan. When assignment occurs, FFS is no longer an option.

The assignment process places beneficiaries into health plans available in the county where the beneficiary resides based on the following criteria:

- The health plan, if any, in which the beneficiary was previously enrolled
- The health plan, if any, in which family members are enrolled
- The health plan selected by a random assignment process if no health plan was identified

There are four easy ways for beneficiaries to enroll:

- Call SCHCC at (877) 552-4642
- Mail or fax the completed enrollment form contained in the enrollment packet
- Online at <http://www.SCchoices.com/>
- In person by meeting with a community enrollment counselor

A beneficiary is enrolled in a Managed Care plan for a period of 12 months. The beneficiary shall remain enrolled in the plan unless one of the following occurs:

- The beneficiary becomes ineligible for Medicaid and/or Managed Care enrollment
- The beneficiary forwards a written request to disenroll for cause
- The beneficiary initiates the disenrollment process during the annual re-enrollment period
- The beneficiary requests disenrollment within the first 90 days of enrollment

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Enrollment of Newborns

Babies born to Medicaid-eligible mothers are automatically deemed Medicaid eligible. As such they are subject to being enrolled into a managed care plan. If, at the time of delivery, the mother is enrolled with an MCO, the baby will be automatically enrolled into the same MCO. If, however, the mother is enrolled with an MHN, or is FFS, the baby will revert to FFS Medicaid for the first year of life. Newborns in FFS are still eligible to enroll in managed care and may be enrolled at anytime by contacting SCHCC.

Babies automatically enrolled into the mother's MCO have a 90-day choice period following birth during which a change to their health plan may be made. Following the 90-day choice period, the newborn enters into his or her lock-in period and may not change health plans for the first year of life without "just cause". The newborn's effective date of enrollment into a managed care plan is the first day of the month of birth.

Providers should refer to the appropriate Medicaid provider manual for additional limitations when providing services to newborns.

Primary Care Provider Selection and Assignment

Upon enrolling into a managed care plan, all beneficiaries are "assigned" to a primary care provider (PCP). If the beneficiary calls SCHCC and chooses a health plan, he or she is asked to select a PCP at that time. If, however, SCHCC assigns the beneficiary to a health plan, the PCP "selection" is handled differently.

For beneficiaries assigned to an MCO, the MCO is responsible for assigning the PCP. For beneficiaries assigned to an MHN, SCHCC is responsible for assigning the PCP. After assignment, beneficiaries may choose to change their PCP. There is no lock-in period with respect to changing PCPs. Enrolled beneficiaries may change their PCP at any time, as often as necessary.

MCO members must call their designated Member Services area to change their PCP. MHN members may call either their Member Services area or speak with their current PCP to change their PCP.

The name of the designated PCP will appear on all MCO cards. Should an MCO member changes their PCP, he or she will be issued a new health plan card from the MCO indicating the PCP change.

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MANAGED CARE DISENROLLMENT PROCESS

OVERVIEW

All disenrollment requests are processed through the enrollment counselor, SCHCC. The beneficiary, the MCO, the MHN, or SCDHHS may initiate the disenrollment process. During the 90 days following the date of initial enrollment with the managed care plan, beneficiaries may disenroll or change plans without cause. Only one change may be requested during this period. Once a change has been requested, or the 90 days following the date of initial enrollment has expired, beneficiaries move into their “lock-in” period. Disenrollment requests made during the lock-in period are processed only for “just cause.” Please refer to the MCO or MHN Policy and Procedures Guide for additional information concerning just cause.

Disenrollment requests made during the lock-in period require the completion of a disenrollment request form, which may be obtained by contacting SCHCC. The form requires the beneficiary to provide information confirming his or her attempt to resolve any issues necessitating disenrollment. That information includes documenting the date and time of the call to the health plan to discuss his or her issues, as well as the person with whom the beneficiary spoke. Failure to provide all required information results in denial of the disenrollment request as all such requests must be reviewed by the SCDHHS Care Management staff.

Upon review by Care Management staff, the managed care plan is notified of the request to disenroll so that a plan representative may follow up with the beneficiary in an effort to address the concerns raised. Managed care plans are required to notify SCDHHS within 10 days of the follow-up results for all complaints or disenrollment requests forwarded to the plan. If just cause is not validated, disenrollment is denied and the beneficiary remains in the managed care plan. A beneficiary’s request to disenroll is honored if a decision has not been reached within 60 days of the initial request. The final decision to accept the beneficiary’s disenrollment request is made by SCDHHS.

If the beneficiary believes he or she was disenrolled in error, it is the beneficiary’s responsibility to contact SCHCC or the managed care plan for resolution. The beneficiary may be required to complete and submit a new enrollment form to SCHCC.

INVOLUNTARY BENEFICIARY DISENROLLMENT

A beneficiary may be involuntarily disenrolled from a managed care plan at any time deemed necessary by SCDHHS or the plan, with SCDHHS approval.

The plan’s request for beneficiary disenrollment must be made in writing to SCHCC using the applicable form, and the request must state in detail the reason for the disenrollment. The request must also include documentation verifying any change in the beneficiary’s status. SCDHHS determines if the plan has shown good cause to disenroll the beneficiary and informs SCHCC of their decision. SCHCC notifies both the plan and the beneficiary of the decision in writing. The plan and the beneficiary have the right to appeal any adverse decision. Managed care plans are

MANAGED CARE SUPPLEMENT**MANAGED CARE DISENROLLMENT PROCESS**

required to inform providers of those beneficiaries disenrolling from their programs. Providers should always check the Medicaid eligibility status of beneficiaries before rendering service.

The plan may not terminate a beneficiary's enrollment because of any adverse change in the beneficiary's health. An exception would be when the beneficiary's continued enrollment in the plan would seriously impair the plan's ability to furnish services to either this particular beneficiary or other beneficiaries.

For additional information, please review the involuntary disenrollment guidelines used by SCDHHS and the Managed Care plans in the **Disenrollment Process** section in the MCO or MHN Policy and Procedures Guide.

MANAGED CARE SUPPLEMENT

EXHIBITS

MANAGED CARE PLANS BY COUNTY

A map of the Managed Care plans by county is available on the SCDHHS Web site at <http://www.scdhhs.gov>, under the *Managed Care Plans* link. Not all MCOs are authorized to operate in every county of the state. Providers should refer to the map for SCDHHS-approved MCOs operating within their service area.

The **Exhibits** section provides the contact information and a card sample for each MCO currently operating in South Carolina.

CURRENT MEDICAID MEDICAL HOMES NETWORK (MHNS)

The following MHN is a participant in the South Carolina Medicaid Managed Care program. MHN beneficiaries should present their South Carolina Healthy Connections Medicaid Insurance card in order to receive health care services. No additional card is necessary. In most cases, referrals to specialty care providers from a PCP do require prior authorization and a prior authorization number from the PCP.

South Carolina Solutions

132 Westpark Blvd
Columbia, South Carolina 29210
(803) 612-4120 or (866) 793-0006
(803) 612-4152 or (888) 893-0018
<http://www.sc-solutions.org/>

CURRENT MEDICAID MANAGED CARE ORGANIZATIONS

South Carolina Medicaid Managed Care Organizations are required to issue a plan identification card to beneficiaries. Beneficiaries should present both the MCO-issued identification card and the Healthy Connections Medicaid Insurance card to obtain services. MCO cards contain important information on the beneficiary (name, plan number), the MCO (toll-free contact numbers), and the PCP.

SAMPLE MEDICAID MCO CARDS


The following card samples are used by MCOs that are currently authorized to operate in South Carolina. Not all MCOs are authorized to operate in every county of the state. Please consult the SCDHHS Web site at <http://www.scdhhs.gov> for the current list of authorized plans and counties.

MANAGED CARE SUPPLEMENT

EXHIBITS

Absolute Total Care

Centene Corporation
 (866) 433-6041
<http://www.absolutetotalcare.com>

		Rx: US Script 1-800-460-8988 BIN:008019
Name: Bob Q. Sample	Effective Date: X/X/XXXX	
ID#: XXXXXXXXXX	DOB: X/X/XXXX	
PCP Name : Dr. John Doe	PCP Phone #:XXX-XXX-XXXX	
If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Absolute Total Care for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Absolute Total Care NurseWise toll-free at 1-866-433-6041, option 7, or TDD/TTY 1-866-912-3609. NurseWise is open 24 hours a day.		


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IMPORTANT MEMBER TELEPHONE NUMBERS	
24/7 Member Line: 1-866-433-6041 TDD/TTY: 1-866-912-3609 24/7 NurseWise®: 1-866-433-6041 , option 7 Prescription Drugs: 1-866-433-6041 Vision/Dental Questions: 1-866-433-6041 TDD/TTY: 1-866-912-3609	
Eligibility: 1-866-912-3604 (MR) Interactive Voice Response 1-866-433-6041 (Provider Services)	
Medical & Behavioral Health Claims	Absolute Total Care Attn: CLAIMS PO Box 3050 Farmington, MO 63640-3821
Healthy Connections Choices at 1-877-552-4642	

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BlueChoice

BlueChoice Health Plan of South Carolina
 (866) 781-5094
<http://www.bluechoicescmedicaid.com>

		Medicaid
MEMBER John Doe	Group No. 023457	
MEMBER ID ZCD1234567890	BIN No. 810075	
	Benefit Plan HIOPT	
	Effective Date 01/01/08	
PRIMARY CARE PROVIDER (PCP) MARY X. JONES, MD 1-999-555-1212		
www.BlueChoiceSCMedicaid.com		

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<p>Member: Show this card and your Medicaid card when you get covered services. See your Member Handbook to learn more about covered benefits.</p> <p>In an emergency, call 911. Or go to the nearest emergency room. You don't need an OK ahead of time. We will pay for these services. Ask the hospital to call your PCP right away.</p> <p>Providers: This card is for ID purposes and does not constitute proof of eligibility.</p> <p>In-state claims: File using payer code 00403</p> <p>Out-of-state claims: File with local BlueCross and/or BlueShield Plus.</p> <p>Hospitals: For inpatient admissions, call 1-866-902-1689 within 24 hours or the first business day.</p>	<p>Customer Care Center: 1-866-781-5094 TTY Line: 1-866-773-9634</p> <p>Prescription Drugs: 1-866-915-0327</p> <p>24-Hour Nurse Help Line: 1-866-577-9710</p> <p>TTY Line: 1-800-368-4424</p> <p>For Current Eligibility: 1-866-757-8286</p> <p>BlueChoice Health Plan of South Carolina P.O. Box 100124 Columbia, SC 29202-3124</p> <p><small>BlueChoice Health Plan is a wholly owned subsidiary of Blue Cross Blue Shield of South Carolina. Both are independent licensees of the Blue Cross and Blue Shield Association. © BlueChoice, BlueCross and BlueShield are registered marks of the Blue Cross and Blue Shield Association. Administered by Well Point Partnership Plan, LLC</small></p>
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MANAGED CARE SUPPLEMENT

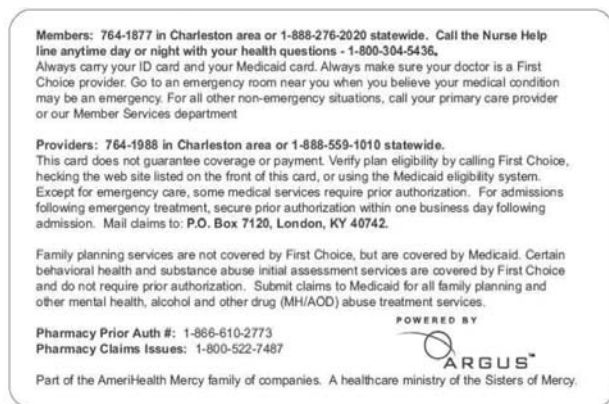
EXHIBITS

First Choice by Select Health

Select Health of South Carolina, Inc.
 (888) 276-2020
<http://www.selecthealthofsc.com>



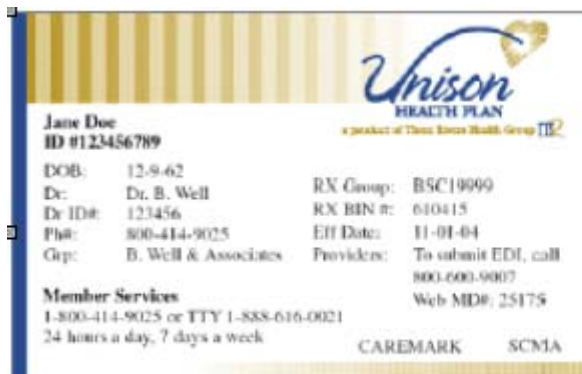
(front)



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Unison Health Plan

(800) 414-9025
<http://www.unisonhealthplan.com>



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MANAGED CARE SUPPLEMENT

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MANAGED CARE SUPPLEMENT

HEALTHY CONNECTIONS KIDS

HEALTHY CONNECTIONS KIDS

OVERVIEW

Healthy Connections Kids (HCK) is not a Medicaid program. It is the stand-alone State Children's Health Insurance Program (SCHIP) for children (under age 19) based upon the State Employee's Health Insurance program. The primary goal of the HCK program is to provide health insurance to children who would otherwise lack coverage. The program is administered through the Medicaid agency (SCDHHS), via the Department of Managed Care.

ENROLLMENT PROCESS

HCK applications are accepted at DHHS county offices using the standard Medicaid application. Upon review by the DHHS county office, if the child is under age 19 and income limitations are within 150% to 200% of the Federal Poverty Level (FPL), he or she is automatically considered for the HCK program. If approved, the member will be placed in Payment Category (PCAT) 99.

In addition to income limitations and age restrictions, HCK members must meet the following criteria:

- Proof of citizenship and SC residency
- Cannot be covered by other health insurance at the present, or within the last 3 months
- Must have a social security number (SSN), or must agree to apply for an SSN
- Countable resources (cash and bank accounts) of no more than \$30,000

Unlike Medicaid, HCK is a mandatory managed care program. The only health care delivery model available is a Managed Care Organization (MCO). All HCK members must participate in managed care, or lose their coverage. Upon being deemed HCK eligible, members are assigned to an MCO using the same guidelines as outlined in the **Enrollment Process** section of this supplement. The MCO will assign the PCP and issue a health plan benefits card. Not all MCOs participate in HCK at this time.

MCOs currently participating in HCK include:

- Absolute Total Care
- First Choice
- Unison

MANAGED CARE SUPPLEMENT

HEALTHY CONNECTIONS KIDS

TRANSFER REQUESTS

Given HCK is a mandatory managed care (MCO) program, HCK members may transfer to another MCO, but not disenroll. Disenrollment from participation with managed care would result in a loss of benefits.

All transfer requests are processed through the enrollment counselor, SCHCC. During the 90 days following the date of initial enrollment with the managed care plan, beneficiaries may change plans without cause. Only one change may be requested during this period. Once a change has been requested, or the 90 days following the date if initial enrollment has expired, beneficiaries move into their “lock-in” period. Transfer requests made during the lock-in period are processed only for “just cause” and require review and approval by the SCDHHS and the MCO.

HCK BENEFITS

HCK benefits are based upon the State Employee’s Health Insurance Plan with the exception of dental and vision services, which are based upon the Medicaid program. Services and claims are managed, authorized, and adjudicated by the MCO. Dental services are the only exception with claims for these services being adjudicated by the SCDHHS. Rendering providers, with the exception of dentists, must join the MCO, or risk non-payment of their claims.

Questions often arise concerning school-based, mental health and/or substance abuse services, and autism benefits. Within the Medicaid program, school-based services are carved out and paid FFS. Within the HCK program, school-based services are not carved out and are not reimbursed by the MCO. Therefore, schools are unable to submit claims for payment. Schools receive federal funds to provide services regardless of insurance coverage, or the family’s ability to reimburse.

Mental health and/or substance abuse services are the responsibility of the MCO. This includes services rendered by state agencies (*i.e.*, the Department of Mental Health, DAODAS, etc.). Providers who render these services must contract with and submit claims to the MCO for reimbursement.

Effective January 1, 2009, autism benefits were included in the HCK program. These benefits include Applied Behavioral Analysis (ABA) therapy.

For questions concerning benefits, HCK members should be directed to their plan’s Member Services area.

MANAGED CARE SUPPLEMENT

HEALTHY CONNECTIONS KIDS



SAMPLE HCK MCO CARDS

Absolute Total Care

Centene Corporation

(866) 433-6041

<http://www.absolutetotalcare.com>

 	Rx: US Script 1-800-460-8988 BIN:008019	
Name: Bob Q. Sample	Effective Date: X/X/XXXX	
ID#: XXXXXXXXXX	DOB: X/X/XXXX	
PCP Name : Dr. John Doe	PCP Phone #:XXX-XXX-XXXX	
If you have an emergency, call 911 or go to the NEAREST emergency room (ER). You do not have to contact Absolute Total Care for an okay before you get emergency services. If you are not sure whether you need to go to the ER, call your PCP or Absolute Total Care NurseWise toll-free at (866) 433-6041, option 7, or TDD/TTY (866) 912-3609. NurseWise is open 24 hours a day.		

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IMPORTANT MEMBER TELEPHONE NUMBERS		
24/7 Member Line: (866) 433-6041 TDD/TTY: (866) 912-3609 24/7 NurseWise®: (866) 433-6041 , option 7 Prescription Drugs: (866) 433-6041 Vision/Dental Questions: (866) 433-6041 TDD/TTY: (866) 912-3609 Behavioral Health (866) 534-5976 Eligibility: (866) 912-3604 (NR) Interactive Voice Response (866) 433-6041 (Provider Services)		
<table style="width: 100%;"> <tr> <td style="width: 50%;"> Behavioral Health Claims: Absolute Total Care Attn: CLAIMS PO Box 7001 Farmington, MO 63640-3811 </td> <td style="width: 50%;"> Medical Claims: Absolute Total Care Attn: CLAIMS PO Box 3050 Farmington, MO 63640-3821 </td> </tr> </table>	Behavioral Health Claims: Absolute Total Care Attn: CLAIMS PO Box 7001 Farmington, MO 63640-3811	Medical Claims: Absolute Total Care Attn: CLAIMS PO Box 3050 Farmington, MO 63640-3821
Behavioral Health Claims: Absolute Total Care Attn: CLAIMS PO Box 7001 Farmington, MO 63640-3811	Medical Claims: Absolute Total Care Attn: CLAIMS PO Box 3050 Farmington, MO 63640-3821	
Healthy Connections Choices at (877) 552-4642		

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First Choice by Select Health


Select Health of South Carolina, Inc.

(888) 276-2020

<http://www.selecthealthofsc.com>

	JOHN DOE ID 12345678 SEX M DOB 01/01/01 SCHIP ID# 1234567890 EFFECTIVE 01/01/02
PRIMARY CARE PROVIDER ABC Pediatrics PCP ID# 12345678 PHONE 843-555-1234 RABIN 100234 RXPON 01230000	 www.selecthealthofsc.com

(front)

Members: 866.299.9594 TTY for hearing impaired: 866.765.9596. Call the Nurse Help Line anytime day or night with your health questions: 800.304.5438. Always carry your First Choice Kids ID card. Always make sure your doctor is a First Choice Kids provider. Go to an emergency room near you when you believe your medical condition may be an emergency. For all other non-emergency situations, call your primary care provider or our Member Services Department.
Providers: 866.299.9594 This card does not guarantee coverage or payment. Verify plan eligibility by calling First Choice Kids or checking the website listed on the front of this card. Except for emergency care, some medical services require prior authorization. For admissions following emergency treatment, secure prior authorization within one business day following admission. Mail medical claims to: P.O. Box 7120, London, KY 40742. Medical Claims Payer ID: 25285. Mail behavioral health claims to: Select Health of SC: MHSA, P.O. Box 6800, Harrisburg, PA 17112. Behavioral Health Claims Payer ID:
Pharmacy Prior Authorization: 866.610.2773 Pharmacy Claims Issues: 800.522.7487
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MANAGED CARE SUPPLEMENT

HEALTHY CONNECTIONS KIDS

Unison Health Plan

(800) 414-9025

<http://www.unisonhealthplan.com>

<★>

Unison Health Plan

<Christopher P. Citizen>
 ID: <010203040>

Plan: <Kids SCHIP>
 Issue Date: <01/01/2009>
 Electronic Payer #: <25175>
 Rx BIN: <610494 >
 PCN: <9999>
 Rx Grp: <ACUSC>

PCP: <Joseph Stephanopolous> <★>
 PCP ID: <000000123456>
 Prov. Grp: <Pacific Coast Medical Group>
 Ph: <412.123.4567>

South Carolina
 Healthy
 Connections **Kids**

Prescription Solutions

(front)

Member Services: 1.800.414.9025
 Hearing Impaired: 711
 Behavioral Health: 1.866.261.7692

In case of emergency, call 911 or go to the nearest emergency room.
 Contact your PCP as soon as possible.

This card is for identification only and is non-transferrable. It does not automatically guarantee eligibility for benefits or create any legal obligations.
 By using this card for services, you agree to the release of medical information, as stated in your member handbook.

FOR PROVIDERS ONLY
 Submit Claims to:
 Unison Administrative Services
 P.O. Box 1147
 Monroeville, PA 15146-5138
 Provider Services: 1.800.600.9007

Utilization Management:
 1.800.366.7304
Pharmacy: 1.877.651.2217
Eligibility: Call the IVR at
 1.888.586.4766

unisonhealthplan.com

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