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MANAGED CARE SUPPLEMENT

MANAGED CARE OVERVIEW

Managed Care is a health care delivery model implemented by the South Carolina Department of Health and Human Services (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

Enrolling in a managed care plan does not limit benefits. Benefits offered under fee for service (FFS) Medicaid, as well as additional or enhanced benefits are provided by all health plans. These additional benefits vary from plan to plan according to the contracted terms and conditions between SCDHHS and the managed care entity. Beneficiaries and providers should contact the health plan with questions concerning additional benefits.

Examples of additional benefits include:

- 24-hour nurse advice line
- Care coordination
- Health management programs (asthma, diabetes, pregnancy, etc.)
- Unlimited office visits
- Adult dental services

The Bureau of Managed Care administers the program for Medicaid-eligible beneficiaries by contracting with Managed Care Organizations (MCOs) to offer health care services. 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. MCO model contracts are approved by the Centers for Medicare and Medicaid Services (CMS) and Medicaid.

This Managed Care supplement is intended to provide an overview of the Managed Care program. Providers should review the MCO Policy and Procedure Guides for detailed program-specific requirements. The guide is located on the SCDHHS Web site at www.scdhhs.gov within the Managed Care section.

The Exhibits section of this supplement provides contact information for MCOs currently participating in the Medicaid Managed Care program as MCOs are subject to change at any time. Providers are encouraged to visit the SCDHHS website (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.
SC Medicaid Managed Care Contact Information

For additional information, contact the Bureau of Managed Care at the following address:

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

Program Description

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 healthcare services to beneficiaries through a network of healthcare professionals, both primary and specialty care, as well as hospitals, pharmacies, etc. This network is developed by contracting with the various healthcare professionals. Providers wanting to contract with an MCO must be enrolled in South Carolina Medicaid with SCDHHS.

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 fee-for-service (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.)

Core Benefits

Managed Care Organizations are fully capitated plans that provide a core benefits 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 additional benefits. These are benefits that go beyond the core package. Additions, deletions, or modifications to additional benefits made during the
contract year must be approved by SCDHHS. These 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 website (www.scdhhs.gov) for a detailed explanation of core benefits and service
limitations.

Services Outside of the Core Benefits

The South Carolina Healthy Connections (Medicaid) program continues to provide and/or
reimburse certain FFS 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 www.scdhhs.gov.

MCO Program Identification (ID) Card

Managed Care Organizations issue an identification card to beneficiaries 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.

To ensure immediate access to services, the provider should verify eligibility and enrollment
regardless of a beneficiary’s ability to supply a SC Medicaid or MCO card. 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
- The MCO and SC Medicaid logos

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 should contact the MCO for billing and prior authorization
requirements prior to rendering services to MCO enrolled beneficiaries. 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, both in and out of network, should contact the beneficiary’s MCO for assistance with prior authorization (PA) requirements before administering services. Each MCO may have different prior authorization requirements and services requiring PA may differ according to the terms of a provider’s contract with an MCO.

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.

Medical Homes Networks (MHNs) - Medically Complex Children's Waiver

SCDHHS administers one MHN specifically for individuals that are enrolled in the Medically Complex Children’s Waiver program. Medical Homes Networks (MHNs) are 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 for this specific population. 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.

The outcome of this medical home is 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.

MHN Program Identification (ID) Card - Medically Complex Children's Waiver

A separate identification card is not issued for members enrolled in this program. Beneficiaries enrolled in this MHN will have only one identification card, the one issued by SC Medicaid. This card does not contain the name or phone number of the assigned PCP. Such information can only be obtained by checking eligibility.

Core Benefits - Medically Complex Children's Waiver

Services provided under this 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 in this program receive unlimited ambulatory visits
Prior Authorizations and Referrals - Medically Complex Children's Waiver

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 for each visit so long as the course of treatment or diagnosis has not changed. 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. 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
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- Speech Therapist Services
- Therapeutic Foster Care Services

Referrals for a Second Opinion - Medically Complex Children's Waiver

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

Referral Documentation - Medically Complex Children's Waiver

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 - Medically Complex Children's Waiver

Beneficiaries can obtain the following services from Medicaid 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 Services
- Medical Transportation Services
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services

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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.
State Agency Services

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 the SCDHHS Provider Service Center (PSC) by calling (888) 289-0709. Providers can also submit an online inquiry at http://scdhhs.gov/contact-us and a provider support representative will respond to you directly.

Primary Care Provider Requirements - Medically Complex Children’s Waiver

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)
- Nurse Practitioners

24-Hour Coverage Requirements - Medically Complex Children’s Waiver

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’s presentation or notification. PCPs must have at least one telephone line that is answered by office staff during regular office hours.

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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.
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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, Specified Low Income Beneficiaries, Emergency Service Only, etc.
- Home- and Community-Based Waiver participants
- PACE 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

Providers should verify beneficiaries’ eligibility through the Web Tool or a point-of-service (POS) terminal prior to delivering services.
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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. Managed Care eligible Medicaid beneficiaries are encouraged to actively enroll with a managed care plan.

SCHCC may be reached by calling (877) 552-4642, or via the SCHCC website: www.SCchoices.com. SCHCC should be contacted for assistance with enrollment, as well as transferring to, or disenrolling from, a health plan regardless of how long a beneficiary has been enrolled in their current health plan.

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 managed care plan choice. Failure to do so will result in managed care plan assignment by SCHCC.

An outreach packet is mailed to beneficiaries who are eligible, but not required, to participate in a managed care plan. Managed care participation is on a voluntary basis for this population. (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. 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 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 open, read, and respond to the enrollment packets to avoid plan assignment. While managed care 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. If a beneficiary fails to act on the initial enrollment packet, outbound calls are placed in an effort to encourage plan selection. If, after the multiple outreach efforts, a beneficiary still fails to respond, he or she will be assigned to a managed care plan.

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 is selected by a Quality Weighted Automated Assignment Algorithm process if no health plan was identified

There are three 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 www.SCchoices.com

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 transfer plans for cause
- The beneficiary initiates the transfer process during the annual re-enrollment period
- The beneficiary requests transfer within the first 90 days of enrollment

**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.

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). When the beneficiary is assigned to an MCO, the MCO is responsible for assigning the PCP. After assignment, beneficiaries may elect to change their PCP. **There is no lock-in period with respect to changing PCPs.** Enrolled beneficiaries may change their PCP at any time and as often as necessary.

MCO members must call their designated Member Services area to change their PCP. The name of the designated PCP will appear on all MCO cards. Should an MCO member change his PCP, he will be issued a new health plan card from the MCO reflecting the new PCP.
MANAGED CARE DISENROLLMENT PROCESS

OVERVIEW

Beneficiaries not required to participate in managed care may request to disenroll and return to fee-for-service Medicaid. Beneficiaries required to participate in managed care may only request to transfer to another health plan as fee-for-service Medicaid is no longer an option for this population.

Disenrollment/transfer requests are processed through the enrollment counselor, SCHCC. The beneficiary, the MCO or SCDHHS may initiate the process. 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 of initial enrollment has expired, beneficiaries move into their “lock-in” period. Requests to change health plans made during the lock-in period are processed only for “just cause.” Please refer to the MCO Policy and Procedures Guide for additional information concerning just cause.

Transfer requests made during the lock-in period require the completion of a Health Plan Change form, which may only 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 Managed Care staff.

Upon review by Managed Care 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 transfer is honored if a decision has not been reached within 60 days of the initial request. The final decision to accept the beneficiary’s request is made by SCDHHS.

If the beneficiary believes he or she was disenrolled/ transferred 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 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 Policy and Procedures Guide.
EXHIBITS

MANAGED CARE PLANS BY COUNTY

A map of the Managed Care plans by county is available on the SCDHHS website at www.scdhhs.gov. Not all MCOs are authorized to operate in every county within 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 NETWORKS (MHNS) FOR THE MEDICALLY COMPLEX CHILDREN’S WAIVER

The following MHN participates with the Medically Complex Children’s waiver and South Carolina Healthy Connections (Medicaid). MHN beneficiaries should present their South Carolina Healthy Connections Medicaid Insurance card in order to receive health care services. No additional card is necessary.

South Carolina Solutions

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

CURRENT MEDICAID MANAGED CARE ORGANIZATIONS

South Carolina Healthy Connections (Medicaid) Managed Care Organizations are required to issue a plan identification card to enrolled beneficiaries. Beneficiaries should present both the MCO-issued identification card and the Healthy Connections Medicaid card. 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 website at www.scdhhs.gov for the current list of authorized plans and counties.
Absolute Total Care
Centene Corporation
(866) 433-6041
www.absolutetotalcare.com

Advicare
Provider and Member Services
1-888-781-4371
www.advicarehealth.com

BlueChoice
BlueChoice HealthPlan of South Carolina Medicaid
(866) 781-5094
www.bluechoicesc.com

First Choice by Select Health
Select Health of South Carolina, Inc.
(888) 276-2020
www.selecthealthofsc.com
Molina Healthcare, Inc.
1-855-237-6178 (Provider Services)
1-855-882-3901 (Member Services)
www.molinahealthcare.com

WellCare Health Plans, Inc.
200 Center Point, Suite 180
Columbia, SC 29210
(888) 588-9842
www.southcarolina.wellcare.com
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