Enrollment/Disenrollment

1. Why would someone not be eligible for managed care enrollment: have to enroll in FFS instead?

   For information concerning eligibility to participate in managed care, refer to the Managed Care Supplement.

2. Why do approved providers (SCDHHS approved) have to go through credentialing with each individual MCO?

   All health plans are required to credential each provider as outlined in 42 CFR 438.214, and the MCO contract and policies & procedures.

3. Who and what phone number would a patient call to change health plans when allowed?

   South Carolina Healthy Connections Choices (SCHCC) at 877-552-4642.

4. Is there a way a provider can find out when the anniversary date of a patient is - the purpose being to remind them to complete the necessary process for renewing Medicaid?

   We hope to be able to provide the managed care anniversary date to providers in the near future via the eligibility verification process. At this time, providers may only confirm this information by contacting the MCO or SCDHHS health plan program manager. Concerning renewal of Medicaid eligibility, all beneficiaries receive information weeks prior to the established renewal date.

5. Do providers need to check eligibility multiple times?

   Yes, as eligibility may change between the time of a scheduled appointment and when it actually occurs.

6. Is there any way to find out how long a beneficiary has been enrolled in a plan?

   No.

7. How can I tell if a patient is enrolled with an MCO or is in one of the MHN programs?

   ALL eligibility and enrollment can be verified using one of the following:

   - ***The SCDHHS Web Tool which is free of charge. For more information call 888-289-0709***
   - ***The Medicaid eligibility Voice Response System at 888-809-3040***
   - ***One of the available card swipe systems***

Upon checking eligibility, providers will be able to determine managed care participation. The Web Tool will list the name and phone number of the MCO, or the name and phone number of the primary care physician for beneficiaries enrolled in an MHN. The IVRS will provide the same information, however it is not shared until the end of the message.

Providers should also ask the beneficiary for their Medicaid and health plan benefit cards; however, possession of a card does not guarantee eligibility. If the beneficiary is in a Managed Care Organization, the beneficiary should have an MCO identification card in addition to the Medicaid ID card.

You must check eligibility before each visit as Medicaid status may change on a daily basis.

8. How do beneficiaries know into which plan they have been enrolled?

Beneficiaries enrolled in a plan will receive a confirmation letter from SC Healthy Connections. Beneficiaries will also receive a packet in the mail from the plan. Beneficiaries enrolled into a Managed Care Organization (MCO) will receive a card from the MCO to be used when they visit the doctor. Beneficiaries enrolled with the Medical Homes Network (MHN), SC Solutions, will not receive a separate card. MHN beneficiaries will only have the SC Healthy Connections ID card.

9. Can enrollees disenroll from their managed care plan?

All enrollees have a 90-day choice period during which a change may be made to their health plan. Beneficiaries required to participate in managed care may choose to transfer to another managed care plan (MCO or MHN). Beneficiaries participating in managed care by choice, may choose to transfer to another managed care plan or return to fee-for-service Medicaid.

10. Can each member of a family have a different plan?

Yes.

11. Why don't you look at the history of a beneficiary and assign them based on providers they already see?

The State Plan stipulates equitable distribution of membership into the plans, the assignment process is automated. As such, there is no way to include a beneficiary's health history in the decision making process given many providers participate in multiple plans and many beneficiaries utilize the services of multiple providers.

12. How long from the date of Medicaid approval does the beneficiary get the Managed Care enrollment package?

Maximus normally generates an enrollment packet within two days of Medicaid approval.

13. Can plans offer incentives such as gift cards or movie tickets to beneficiaries who sign with them?

These can be given to <u>members</u> to encourage or reward healthy behaviors, but plans cannot offer gifts as incentives to join or enroll. If you see or hear of plans offering these types of incentives to join, please report specific information to the Managed Care staff at (803) 898-4614.

14. Will beneficiaries sign up annually with managed care?

No. The beneficiary will remain in the same managed care plan unless they choose otherwise. Upon completion of the annual review process, the beneficiary will have another 90-day window during which to change health plans. Maximus sends beneficiaries an anniversary letter to inform them that they may make a change in their health plan enrollment.

15. How is it determined from which plans a beneficiary can choose?

A beneficiary's choice is dependent upon plans that are operational within their county of residence at the time the choice is made. All plans are not operational in every county within the state of SC. Beneficiaries may choose a plan that is not operational within their county of residence, but they must inform Maximus upon calling of their choice and reason for choosing such a plan.

16. Does the beneficiary have to choose fee-for-service (FSS)?

Fee-for-service (FFS) is no longer an option for those beneficiaries for which managed care participation is now mandatory. For those beneficiaries not required to participate in managed care, they may only participate in managed care by choice; otherwise, they will remain in FFS.

17. If a beneficiary selects fee-for-service and their review is coming up, do they have to make that choice again or will they be auto-assigned?

FFS is no longer an option for most Medicaid beneficiaries as most are now required to participate in managed care. For those beneficiaries where managed care participation is not required, they will remain in the same plan they are currently on unless they choose otherwise and they may choose fee-for-service.

18. If a beneficiary is in a plan and looses eligibility, do they choose again?

If they regain eligibility within 60 days, they automatically go back into the same plan. If longer than 60 days, they go through the assignment process again as an approval.

19. Can the beneficiary request a change of plan on the website if past the 90 days?

If the beneficiary is within their 90-day period, changes can be made on the web. If their 90-day period has expired, or they have already made one change to their health plan assignment, they have to request a disenrollment form from SC Healthy Connections Choices (Maximus).

20. Can a beneficiary call Maximus and change plans over the phone?

Yes. During the first 90 days of enrollment a beneficiary may change health plans <u>one time</u> without cause. A Maximus Enrollment Counselor will process the request made within the first 90 days without hesitation. After one change has been made, or the first 90 days of enrollment have expired, the Enrollment Counselor will mail a disenrollment request form to the beneficiary. The beneficiary must complete the form and return it for medical review and processing. Every attempt is made to keep the beneficiary in their plan, or move then to another managed care plan.

21. If a beneficiary chooses a plan that their doctor is accepting, but later discovers that the county does not have an available pharmacist that accepts the plan, can they disenroll after the 90 days?

All plans are required to contract with pharmacies in every county. As such, the beneficiary must have his/her prescriptions filled at the in-network pharmacy provider. For assistance locating an in-network pharmacy, the beneficiary should contact their plan's Member Services area.

22. If a beneficiary chooses fee-for-service and 90 days has passed, can they select a Managed Care plan after the 90 days or will they have to wait until their review?

Eligible Medicaid beneficiaries in FFS can choose to participate in a managed care plan at any time by calling the enrollment counselor at 1-877-552-4642.

23. If a mother delivers a child, is the baby automatically assigned to the plan that the mothers is in?

Yes, if the mother is enrolled with one of the MCOs. If the mother is enrolled with one of the MHNs, the MHN outreaches to mom to encourage participation with the MHN.

24. When does a newborn have the opportunity to choose?

A choice can be made for a newborn any time from birth to their annual application at age 1.