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MANAGED CARE SUPPLEMENT

PROGRAM OVERVIEW

Managed Care is a health care delivery model implemented by SCDHHS to establish a medical home for all Medicaid-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 to 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 Department of Managed Care administers the program for Medicaid beneficiaries by contracting with Managed Care Organizations (MCOs) and Medical Homes Networks (MHNs) to offer health care services. Core services across the managed care plans do not vary; however, enhanced services may vary from plan to plan according to the contracted terms and conditions between SCDHHS and the managed care contractor. Managed Care Organizations and the Medical Homes Network may offer additional or enhanced services, such as unlimited visits, suspension of copayment requirements, adult dental, or adult vision benefits. Providers should contact the MCO or the MHN directly for 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 SCDHHS Web site, **www.scdhhs.gov**, for the most current listing of participants and the counties in which they are authorized to operate.

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, **www.scdhhs.gov**, within the Managed Care section.

SC MEDICAID MANAGED CARE CONTACT INFORMATION

For additional information, contact the

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

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PROGRAM OVERVIEW

PROGRAM DESCRIPTIONS

Managed Care Organizations (MCOs)

Managed Care Organizations enter into a contract with SCDHHS to provide health care services to beneficiaries through a network of health care professionals. MCOs are responsible for providing core services to Medicaid-eligible individuals as specified in their contract with SCDHHS. Core services are discussed further in the **Core Benefits** section of this supplement.

An MCO must receive a Certificate of Authority from the South Carolina Department of Insurance and must be licensed as a domestic insurer by the State to render Medicaid managed care services. 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). A sample contract is located at the SCDHHS Web site, under *Benefits Plans > MC Information > Managed Care Organization (MCOs) > Sample MCO Contract*.

Medical Homes Networks (MHNs)

A Medical Homes Network (MHN) is a group of physicians who have agreed to serve as Primary Care Case Management (PCCM) providers. They partner with a Care Coordination Services Organization (CSO) to accept the responsibility for providing medical homes for beneficiaries and for managing beneficiaries' care. The PCCM works 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. 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.

MHNs are under contract with SCDHHS through the CSO. 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*.

BENEFICIARY ELIGIBILITY

Medicaid-eligible individuals must meet the eligibility requirements under the **Eligibility Determination** in Section 1 of this manual to participate in the Managed Care program. The Enrollment Counselor, South Carolina Healthy Connections Choices (SCHCC), is responsible for processing the enrollment of Medicaid-eligible beneficiaries into a Managed Care plan. Additional information concerning the enrollment process is discussed in the "Enrollment Counselor Services" section of this supplement.

MCOs issue an identification card to eligible beneficiaries that contains the phone numbers for the SC Medicaid Resource Center, as well as a phone number to assist providers with billing issues specific to the managed care plan. **A beneficiary must present both the South Carolina Healthy Connections Medicaid ID card and the MCO-issued card before receiving services.**

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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.

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, Managed Care program information is given at the end of the inquiry.

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

- 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, etc.
- Home- and Community-Based Waiver participants
- Medically Fragile Children's Program participants
- Hospice participants
- Beneficiaries covered by an MCO through third-party coverage
- Beneficiaries enrolled in another Medicaid managed care plan

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

- Medically Fragile Children's Program participants
- Individuals institutionalized in a public facility
- Participants in limited benefits programs such as Family Planning Waiver, Specified Low Income Beneficiaries, etc.
- Beneficiaries enrolled in another Medicaid managed care program

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MANAGED CARE ORGANIZATIONS

OVERVIEW

South Carolina Medicaid contracts with Managed Care Organizations as a way to provide a medical home to members, increase the level of care and positive health outcomes, and help control the cost of services. MCOs consist of a network of providers that render core benefits to Medicaid MCO-eligible beneficiaries. This section of the supplement only reflects the general Medicaid policies and procedures that govern Managed Care Organizations in South Carolina. The 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, **www.scdhhs.gov**. MCO providers are not required to enroll in SC Medicaid, as claims filed to the MCO will be processed and paid directly 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 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 the very least, 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, **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. Such services are filed to SC Medicaid for processing and payment.

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MCOs are responsible for beneficiaries' continuity of care by ensuring appropriate referrals and linkages to the Medicaid FFS providers.

The following Medicaid-covered services are paid FFS and should be coordinated with FFS providers through MCOs:

- Institutional Long-Term Care Facilities/Nursing Homes Services
- Mental Health, Alcohol and Other Drug Abuse Treatment Services
- Non-Emergency Transportation Services
- Vision Care Services
- Dental Services
- Chiropractic Services
- Rehabilitative Therapies for Children — Non-Hospital-Based Services
- Targeted Case Management Services
- Home- and Community-Based Waiver Services
- Pregnancy Prevention Services — Targeted Populations
- MAPPS Family Planning Services
- Organ Transplants Services

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. For FFS providers treating beneficiaries in the emergency room, they should contact the MCO for billing requirements. 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

OVERVIEW

Medical Homes Networks are Medicaid's Primary Care Case Management programs that link Medicaid beneficiaries with a primary care provider (PCP). The PCP works in partnership with the beneficiary to provide and arrange for most of the beneficiary's health care needs. 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 care managers, who assist in developing, implementing, and evaluating the predetermined care management strategies of the network.

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, **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)

South Carolina Medicaid providers who are interested in participating in an MHN should call the SCDHHS Division of Care Management at (803) 898-4614. The Medical Homes Program Manager will assist providers with the various network options available.

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)

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MEDICAL HOMES NETWORKS

Other provider types that wish to participate in a Medical Homes Network should contact the local Care Coordination Services Organization. The decision to allow other provider types to join the network is at the discretion of the MHN.

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

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 copay 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 an authorization 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.

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. 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

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- 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
- Nursing Home Services
- Obstetrician and Gynecologist Services
- Optician Services
- Optometrist Services
- Pharmacy Services
- State Agency Services[2]
- 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, **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.

Primary care providers who enter into a contract with a Medical Homes Network are expected to meet the following criteria:

- PCPs are required to accept new Medicaid beneficiaries who wish to enroll with the MHN; however, PCPs may not exceed the practice's established capacity.
- PCPs must provide primary care and care coordination services.
- PCPs must provide or arrange for primary care coverage for services, consultations or referrals, and treatment for emergency medical conditions, 24 hours per day, 7 days per week. (See the "24-Hour Coverage Requirement" section later in this supplement.)

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- PCPs must provide preventive services as defined by the MHN.
- PCPs must offer member education services to all beneficiaries and potential beneficiaries, as well as disease management services to beneficiaries for whom the services are appropriate.
- PCPs must establish and maintain inpatient hospital admitting privileges, or enter into an arrangement with another physician or group practice for the management of the beneficiary's inpatient hospital admissions. (See the "Hospital Admitting Privileges Requirement" section later in this supplement.)
- PCPs assist beneficiaries by providing systematic, coordinated care, and are responsible for all referrals to other providers for additional medically necessary.
- PCPs are required to follow the recommended Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services screening schedules, as dictated by CMS.
- PCPs are required to utilize the following standards for appointment availability:
    - Emergency care must be administered to the beneficiary immediately upon presentation or notification.
    - Urgent care must be administered to the beneficiary within 48 hours of presentation or notification.
    - Routine sick care must be administered to the beneficiary within three days of presentation or notification.
    - Routine well care must be administered to the beneficiary within 45 days of presentation or notification (15 days if pregnant).
- PCPs are required to utilize the following standards for office wait times:
    - For walk-ins, the PCP must render services to the beneficiary within two hours, or schedule an appointment within the standards of the appointment availability criteria listed above.
    - For scheduled appointments, the PCP must render services to the beneficiary within 45 minutes.
    - For a life-threatening emergency, the PCP must render services to the beneficiary immediately.

The failure to meet the above requirements could result in the imposition of sanctions on the PCP, the CSO, or the MHN as a whole.

MHNs that contract with SCDHHS must adhere to a Bill of Rights guarantee to their contracting providers. Providers should review their rights detailed in the "Providers' Bill of Rights" section of the MHN Policy and Procedures Guide.

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,

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consultation, and/or authorization or referral for service 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.

PCPs must provide beneficiaries with an after-hours telephone number. The after-hours telephone number must provide the following connection to the PCP:

1. An answering service that promptly contacts the PCP or the PCP-authorized medical practitioner
2. A recording that directs the beneficiary to an alternate telephone number to contact the PCP or the PCP-authorized medical practitioner
3. A system that automatically transfers the call to a telephone line that is answered by a person who will promptly contact the PCP or the PCP-authorized medical practitioner
4. A call center system

A hospital may be used for the 24-hour telephone coverage requirement under the following conditions:

- The access line is not answered by an emergency department staff member
- The PCP establishes a communication and reporting system with the hospital
- The PCP reviews the results of all hospital-authorized services

An office telephone line does not meet the telephone coverage requirements when the telephone is not answered after-hours, or answered with a recorded message instructing the beneficiary to call back during office hours, or answered with instructions to go to the emergency department for care. PCPs are encouraged to refer beneficiaries with after-hours urgent medical problems to an urgent care center rather than the emergency room, provided there is one accessible to them.

Hospital Admitting Privileges Requirement

PCPs must establish and maintain hospital admitting privileges or enter into a formal arrangement with another physician or group practice for the management of beneficiary hospital admissions. An acceptable arrangement is when a physician, a group practice, a hospital group, or a physician call group (not necessarily an MHN provider) enrolled with the South Carolina Medicaid program has admitting privileges, or formal arrangements, at a hospital located within 30 miles, or within a 45-minute drive time from the PCP's office. If there is no hospital that meets the above geographic criterion, the closest hospital to the PCP's practice is acceptable.

A voluntary written agreement between the PCP and a physician or group, who agrees to admit beneficiaries for the PCP, fulfills this requirement for participation. By completing and signing the agreement, the physician and/or group agrees to accept responsibility for admitting and coordinating medical care for the beneficiary throughout his or her inpatient hospital stay. The CSO must keep the original agreement on file. Hospital admitting agreements with unassigned call doctors are unacceptable.

Exceptions may be granted in cases where it is determined that the benefit of a PCP's participation outweighs the PCP's inability to comply with the admitting privileges requirement.

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MEDICAL HOMES NETWORKS

The MHN Hospital Admission Agreement/Formal Arrangement Form is available in the "Forms" section of this supplement.

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. Sample copies of the WIC Referral Form and the Medical Record Release Form are available in the "Forms" section of this supplement.

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

Medical Records

PCPs must transfer the beneficiary's medical record to the receiving provider upon the change of the PCP and as authorized by the beneficiary within 30 days of the date of the request.

Guidelines have been established concerning documenting and maintaining medical records for MHN beneficiaries. For detailed information concerning those guidelines, refer to the MHN Policy and Procedures Guide.

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MANAGED CARE SUPPLEMENT

MARKETING AND EDUCATIONAL MATERIALS

OVERVIEW

The South Carolina Medicaid Managed Care program has implemented general marketing policies that govern how both MCOs and MHNs may contact and educate beneficiaries concerning their plans. Effective May 1, 2008, MCOs and MHNs may no longer enroll beneficiaries into their plans. All plans must refer beneficiaries to SCHCC for assistance with enrollment. The MCO's and MHN's staff, agents, officers, subcontractors, volunteers, or anyone acting for or on behalf of the managed care plan must adhere to the SCDHHS-approved guidelines at all times. **Under no circumstance will a managed care plan or its representative circumvent established marketing and enrollment policies.**

The marketing plan and all related accompanying materials such as brochures, fact sheets, posters, lectures, videos, community events and presentations, are governed by the requirements of the CMS protocol, 42 CFR 438.104. All marketing and related activities must receive prior written approval from SCDHHS or its designee.

The following brief overviews of the Marketing and Beneficiary Education requirements are only included for guidelines and are not an all-inclusive statement of South Carolina Medicaid policies. Providers should refer to the complete list of requirements outlined in the MCO Policy and Procedures Guide and the MHN Policy and Procedures Guide.

GENERAL MARKETING POLICIES

Examples of general marketing policies that govern managed care marketing activities include:

- No direct marketing to Medicaid applicants or beneficiaries in person, through direct mail advertising, or telemarketing
- No direct or indirect door-to-door, telephonic, or other "cold call" marketing activities. Health plan staff shall not make direct contact with beneficiaries to solicit enrollment.
- No repeated follow-up calls unless specifically requested by the beneficiary. Repeated **unsolicited** contacts with Medicaid beneficiaries are prohibited.

MEDICAID APPLICANT OR BENEFICIARY CONTACT

A managed care plan's marketing staff member may contact a Medicaid applicant or beneficiary under certain circumstances described in the MCO or MHN Policy and Procedures Guide. Examples of when a staff member may initiate contact with a beneficiary are:

- When the beneficiary is listed on the Monthly Member Report for Medicaid recertification or eligibility
- When the beneficiary is listed on the Monthly Member Report as voluntarily disenrolled

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MARKETING AND EDUCATIONAL MATERIALS

MATERIALS, MEDIA, AND MAILINGS

All forms of media are acceptable for advertisements with written approval from SCDHHS. Managed care plan network providers may use SCDHHS-approved model letters to inform beneficiaries about their participation status in the Managed Care program. Providers' model letters must also be in compliance with the South Carolina Department of Insurance advertisement policies.

Materials, media, and mailings used by managed care plans must include the Resource Center's toll-free telephone number, (888) 549-0820, as well as the plan's toll-free telephone number. Promotional materials (items designed as "giveaways" at exhibits) are excluded. Providers should contact their managed care program manager to resolve material, media, and mailing issues. Mass mailings are limited to the managed care plans service area, and cannot be directed only to Medicaid beneficiaries.

Managed care plans are responsible for developing and distributing their own beneficiary-specific marketing and educational materials including, but not limited to, evidence of coverage, a beneficiary handbook, and beneficiary educational opportunities.

Passive distribution sites used for advertisement are allowed and are defined as any site approved by contract with SCDHHS such as churches, providers offices, schools, community centers, etc.

Providers should review additional policies and procedures outlined in the MCO or MHN Policy and Procedures Guide.

Member Education Specific to a Medical Homes Network

The MHN must be actively involved in beneficiary education. The CSO provides the primary care physician with a monthly member listing of all new enrollees.

MHNs provide an orientation for new beneficiaries to discuss the following guidelines:

- The PCP is required to provide medical advice and care 24 hours per day, 7 days per week, and to provide the preferred method for contacting the PCP.
- The beneficiary is responsible for bringing his or her Medicaid ID card to each appointment.
- The beneficiary must contact the PCP for a referral before going to another provider.
- The beneficiary should be encouraged to contact the PCP before going to an emergency care facility unless the beneficiary feels that his or her life or health is in immediate danger.
- The beneficiary should schedule regular preventive care visits to his or her PCP for preventive care such as EPSDT screenings for children, immunizations, checkups, mammograms, cholesterol screenings, adult health assessments, and diabetic screenings.

Member Services

Managed care plans must maintain an organized and integrated Member Services function to assist beneficiaries in understanding plans' policies and procedures. The Member Services

function provides information to beneficiaries about the plan's primary care providers, how to facilitate referrals to participating specialists, and assistance in the resolution of service and/or medical delivery concerns expressed by beneficiaries.

Managed care plans also provide the following services through their Member Services function:

- Identify and educate beneficiaries who access their system inappropriately and provide additional education as needed
- Provide a written description of its Member Services function to give beneficiaries no later than 14 business days from the receipt of the enrollment data from SCDHHS
- Adhere to a Bill of Rights guarantee to Medicaid beneficiaries. For additional information, providers should review the "Member Services" and the "Members and Potential Members Bill of Rights" sections in the MCO or MHN Policy and Procedures Guide

COMMUNITY EVENTS AND FORUMS

Managed care plans may conduct marketing activities only with prior written approval from SCDHHS. SCDHHS' approval is specific by event, site, and date including activities in the plan's providers' offices. **SCDHHS reserves the right to attend all community events.**

The guidelines for marketing events and community forum activities can be found in the MCO or MHN Policy and Procedures Guide on the SCDHHS Web site, **www.scdhhs.gov**.

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ENROLLMENT PROCESS

OVERVIEW

Beneficiaries may enroll online, over the phone, or by mail. The total Managed Care enrollment per full-time physician is limited to 2500 members, unless otherwise approved by SCDHHS.

SC HEALTHY CONNECTIONS CHOICES (SCHCC)

SCDHHS has instituted a new enrollment process for Medicaid managed care called South Carolina Healthy Connections Choices (SCHCC). SCHCC serves as the enrollment counselor providing services throughout the state of South Carolina. SCHHC informs newly eligible Medicaid beneficiaries, and beneficiaries going through the yearly eligibility redetermination process, of their various Managed Care choices. Beneficiaries are mailed either an enrollment or an outreach packet.

The enrollment packet is sent to those beneficiaries eligible for managed care plan assignment. The outreach packet is mailed to those beneficiaries that are eligible to participate in a managed care plan, but are not eligible for plan assignment.

Those 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.)

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 change the plan into which they are enrolled, and the beneficiary 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 PERIOD

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 PROCESS

ENROLLMENT OF NEWBORNS

Newborns of Medicaid MCO enrolled beneficiaries will be enrolled into the MCO's plan, unless the mother or guardian has specified otherwise prior to delivery. To ensure the continuity of care in the crucial first month of the newborn's life, every effort is made by MCOs to expedite the enrollment of newborns into their plan. SCDHHS enrolls newborns into the same MCO plan as the mother for the first 90 calendar days, unless otherwise specified by the mother/guardian. The newborn is enrolled in the plan through the end of the month in which the 90th day falls. If the mother/guardian fails to request the newborn be disenrolled from the plan to which he or she is assigned, the newborn will remain in the MCO assigned at birth for the remainder of the first year of life. The newborn's effective date of enrollment is the first day of the month of birth.

Newborns of FFS or MHN Medicaid beneficiaries are not automatically enrolled into a managed care plan. The newborn remains FFS for the first year of life unless the parent/guardian requests enrollment into a managed care plan. At the child's annual redetermination, if the child is eligible for enrollment into a managed care plan, the parent/guardian is contacted by SCHCC.

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

ENROLLMENT FORMS

All enrollments into a managed care plan must be completed using the SCHCC form (See the "Forms" section of this supplement). All forms must be forwarded to SCHCC for processing. In addition, all calls concerning enrollment, disenrollment, and changes to existing plans are handled by SCHCC. SCDHHS Managed Care staff will provide support as needed. Managed care plans are no longer permitted to distribute enrollment forms, or provide assistance completing enrollment forms.

MANAGED CARE SUPPLEMENT

DISENROLLMENT PROCESS

OVERVIEW

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. Following the initial 90-day period, disenrollment requests are processed only for "just cause." Please refer to the MCO or MHN Policy and Procedures Guide for additional information concerning just cause. SCHCC processes all disenrollment requests regardless of when the request was initiated, unless the request was made directly to the program manager.

If after the initial 90-day period, the beneficiary requests disenrollment, the request is reviewed by the program manager and health plan for just cause. 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. If just cause is validated, the program manager is responsible for capturing the disenrollment request and forwarding it to Managed Care Enrollment for processing. If just cause is not validated, disenrollment is denied and the beneficiary remains in the managed care plan. Managed care plans are required to notify SCDHHS of the follow-up results for all complaints or disenrollment requests forwarded to the 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 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.

MANAGED CARE SUPPLEMENT

DISENROLLMENT PROCESS

For additional information, you may 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

ENROLLMENT COUNSELOR SERVICES

SERVICE DESCRIPTION

South Carolina Healthy Connections Choices is the name of the enrollment counseling service contracted with SC Medicaid. Information concerning SCHCC services can be accessed at **www.scchoices.com**. SCHCC is responsible for contacting and enrolling all Medicaid beneficiaries.

ROLLOUT PLAN

SCHCC began rolling out the managed care plan by regions. Enrollment is voluntary, and current beneficiaries (with regular, FFS Medicaid) can enroll anytime after the rollout start date within their region. The SCHCC Enrollment Counselor mails beneficiaries who are newly eligible for Medicaid, or who are eligible for re-enrollment in a Medicaid health care plan, an enrollment or outreach packet.

CONTACT INFORMATION

Beneficiaries may contact the Enrollment Counselor by telephone, fax, TTY for the hearing impaired, or the Web site.

Telephone Number: (877) 552-4642
Fax: (877) 552-4672
TTY: (877) 0552-4670
Email: SCHCC@maximus.com
Web site: **www.scchoices.com**

ENROLLMENT PERIOD

After initial enrollment into a Managed Care plan, beneficiaries have 90 days to make a change, join another plan, or return to FFS Medicaid. After the 90-day period, all beneficiaries will remain in their chosen plan for the remainder of the 12-month period. The enrollment may be terminated prior to the 12-month period for just cause, such as the inability of the plan to provide adequate access to services. (See the "Disenrollment Process" section of this supplement).

Enrollment and disenrollment forms are included in the "Forms" section of this supplement.

MANAGED CARE SUPPLEMENT

ENROLLMENT COUNSELOR SERVICES

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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 **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
www.sc-solutions.org

MANAGED CARE SUPPLEMENT

EXHIBITS

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.

Medicaid 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.

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

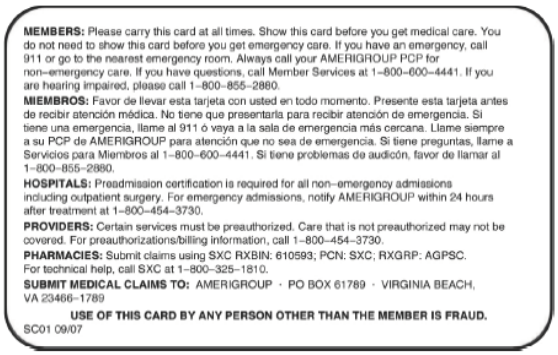
The following card samples are used by MCOs that are currently authorized to operate in South Carolina. Not all MCOs are authorized to operate in every county of the state. Please consult the SCDHHS Web site at **www.scdhhs.gov** or call the SCDHHS Division of Care Management at (803) 898-4614 for the current list of authorized plans and counties.

MANAGED CARE SUPPLEMENT

EXHIBITS

AMERIGROUP Community Care
Amerigroup Corporation
(888) 821-1108
www.myamerigroup.com

(front)



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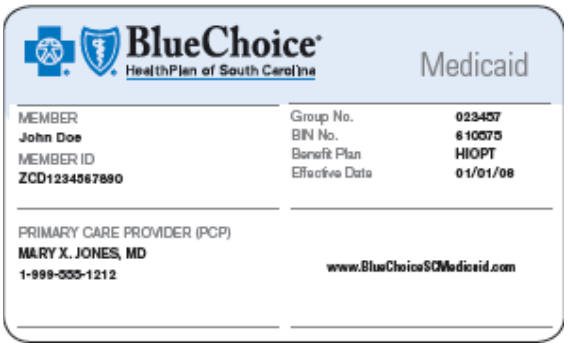
BlueChoice Health Plan of South Carolina
BlueCross BlueShield of South Carolina
(866) 781-5094
www.bluechoicescmedicaid.com



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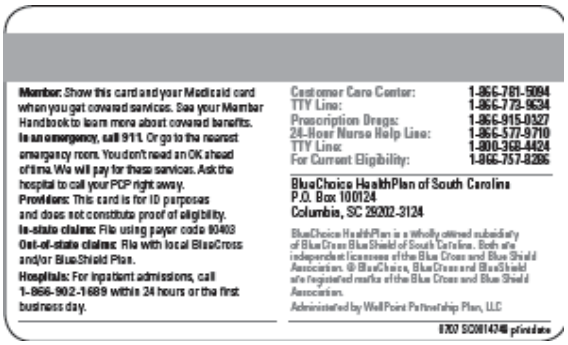

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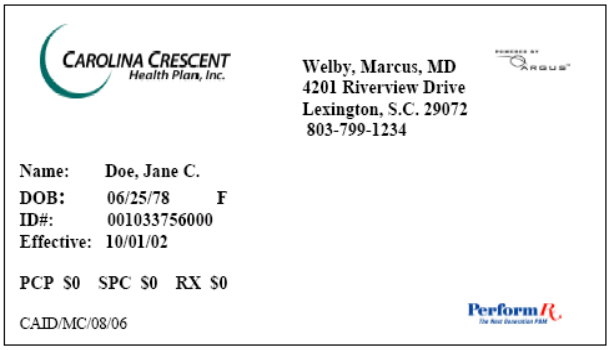
MANAGED CARE SUPPLEMENT

EXHIBITS

Carolina Crescent Health Plan, Inc.

Virginia Commonwealth University Health System
(866) 748-8661
www.CarolinaCHP.com


CAROLINA CRESCENT Health Plan, Inc.

Welby, Marcus, MD
4201 Riverview Drive
Lexington, S.C. 29072
803-799-1234

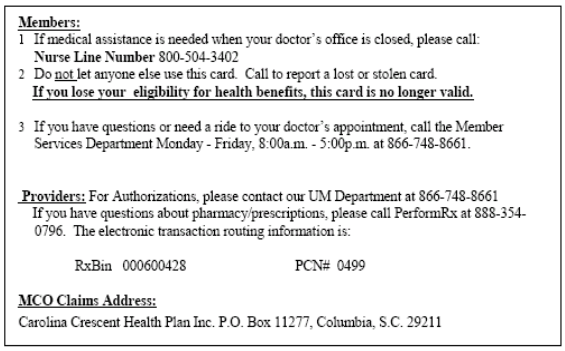
Name: Doe, Jane C.
DOB: 06/25/78 F
ID#: 001033756000
Effective: 10/01/02

PCP $0 SPC $0 RX $0

CAID/MC/08/06

PerformRx

(front)


Members:
1 If medical assistance is needed when your doctor's office is closed, please call: **Nurse Line Number** 800-504-3402
2 Do not let anyone else use this card. Call to report a lost or stolen card. **If you lose your eligibility for health benefits, this card is no longer valid.**
3 If you have questions or need a ride to your doctor's appointment, call the Member Services Department Monday - Friday, 8:00a.m. - 5:00p.m. at 866-748-8661.

Providers: For Authorizations, please contact our UM Department at 866-748-8661 If you have questions about pharmacy/prescriptions, please call PerformRx at 888-354-0796. The electronic transaction routing information is:

RxBin 000600428 PCN# 0499

MCO Claims Address:
Carolina Crescent Health Plan Inc. P.O. Box 11277, Columbia, S.C. 29211

(back)

CHCcares of South Carolina

Coventry Health Care, Inc.
(866) 802-2474
www.chcsouthcarolina.com

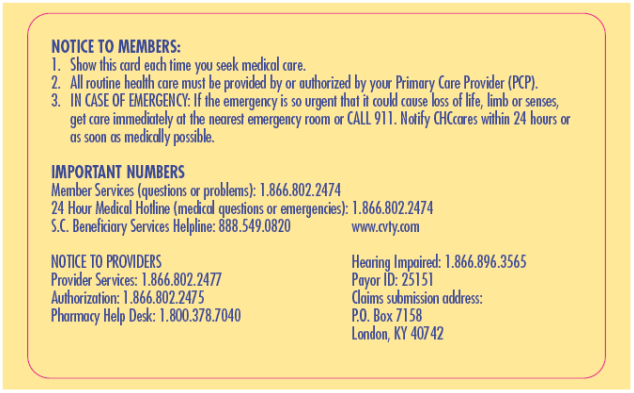

CHCcares

140 Stoneridge Drive, Suite 200
Columbia, SC 29210 ■ 1.866.802.2474

Membership Card

Member Name: Jane A. Doe
CHCcares #: 123456789
Primary Care Provider: XYZ and associates
PCP Phone: (800) 123.4567
Co-pays: ER $0, PCP $0, Specialists $0, Inp. $0
CHCcares of South Carolina brought to you by Wellpath of South Carolina, Inc.

(front)


NOTICE TO MEMBERS:
1. Show this card each time you seek medical care.
2. All routine health care must be provided by or authorized by your Primary Care Provider (PCP).
3. IN CASE OF EMERGENCY: If the emergency is so urgent that it could cause loss of life, limb or senses, get care immediately at the nearest emergency room or CALL 911. Notify CHCcares within 24 hours or as soon as medically possible.

IMPORTANT NUMBERS
Member Services (questions or problems): 1.866.802.2474
24 Hour Medical Hotline (medical questions or emergencies): 1.866.802.2474
S.C. Beneficiary Services Helpline: 888.549.0820 www.cvty.com

NOTICE TO PROVIDERS
Provider Services: 1.866.802.2477
Authorization: 1.866.802.2475
Pharmacy Help Desk: 1.800.378.7040

Hearing Impaired: 1.866.896.3565
Payor ID: 25151
Claims submission address:
P.O. Box 7158
London, KY 40742

(back)

MANAGED CARE SUPPLEMENT

EXHIBITS

First Choice of South Carolina

Select Health of South Carolina, Inc.
(888) 276-2020
www.selecthealthofsc.com

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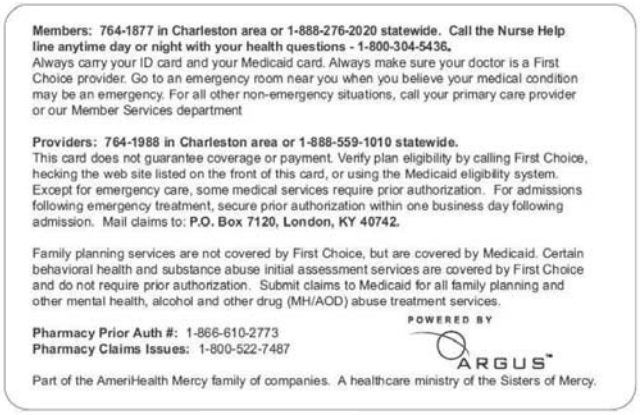

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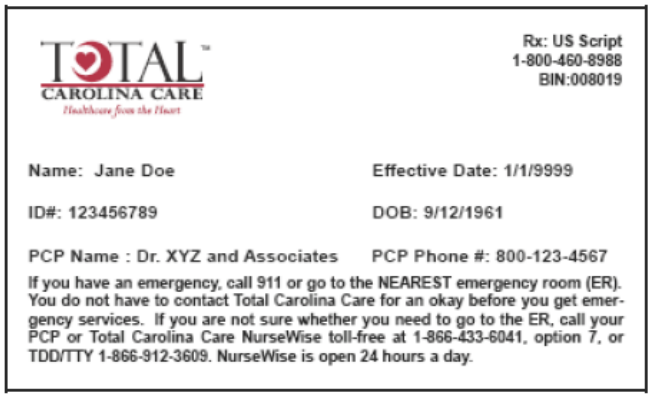
Total Carolina Care Inc.

Centene Corporation
(866) 433-6041
www.totalcarolinacare.com



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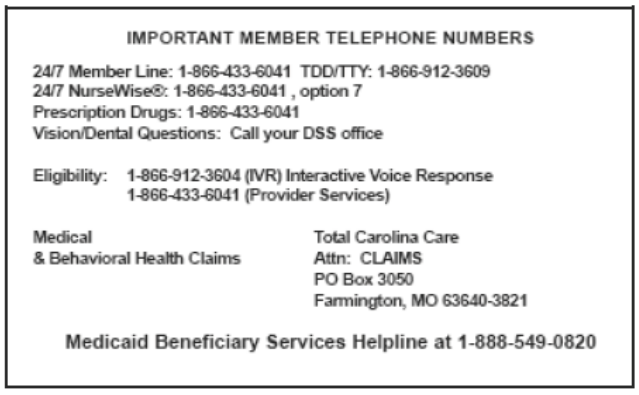

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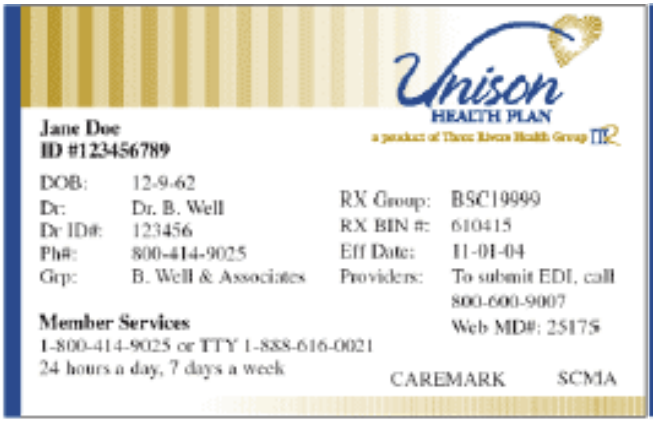
MANAGED CARE SUPPLEMENT

EXHIBITS

Unison Health Plan
(800) 414-9025
www.unisonhealthplan.com



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MANAGED CARE SUPPLEMENT

FREQUENTLY ASKED QUESTIONS (FAQS)

The SC Medicaid Managed Care program staff has collected a list of frequently asked questions and answers. This list is not all inclusive, but represents the major topics of concern by providers about the Managed Care program policies and procedures. For additional information about the Managed Care program, please refer to the "Contact Information" section of this supplement.

MANAGED CARE SUPPLEMENT

FAQs

1. How can I tell if a beneficiary is enrolled with an MCO (Managed Care Organization) or is in the MHN program?

All enrollments are verified by the following two-step process:

1. Ask the beneficiary for their Healthy Connections Medicaid card. Possession of a card does not guarantee eligibility. If the beneficiary is enrolled in an MCO, the beneficiary should present an MCO ID card, as well.
2. Access one of the following SC Medicaid electronic systems to check eligibility:
   - The Web Tool – You can verify beneficiary eligibility online by entering their Medicaid ID, the social security number, or a combination of the beneficiary's name and date of birth. If you wish to check eligibility via the Web Tool, contact the SC Medicaid EDI Support Center toll-free at 1-800-289-0709, and complete a Trading Partner Agreement (TPA).
   - The Medicaid Interactive Voice Response System (IVRS) – You can verify beneficiary eligibility utilizing the IVRS toll-free telephone, 1-888-809-3040. To access the IVRS, you use your six-character Medicaid provider ID. The managed care information is given at the end of the message. For beneficiaries enrolled in an MCO, the message indicates the managed care program, the name of the MCO and the MCO's Member Services telephone number. For beneficiaries enrolled in an MHN, the message indicates the beneficiary is in a managed care program, the name of their primary care physician (PCP), and the physician's telephone number.

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

2. Do all Medicaid services require authorization?

No. Not all Medicaid services require prior authorization (PA). You can find a list of services requiring PA, as well as the process for securing authorization in the provider or member services manuals of each plan. If you are unsure, it is always best to check with the beneficiary's Medicaid managed care plan.

3. What if MCO or MHN enrollees assigned to my practice need health care my office cannot provide?

MCOs – PCPs are responsible for referring enrollees assigned to their practice to specialists and other health services, as needed. Payment may be denied if the PCP fails to authorize treatment.

MHNs – PCPs are responsible for referring members to other providers and/or specialists for treatment and to authorize that treatment. If a member fails to establish a medical record with the PCP, the Care Coordination Services Organization (CSO) is responsible for providing the authorization. Payment may be denied if the PCP or CSO fails to authorize treatment.

MANAGED CARE SUPPLEMENT

FAQs

4. Does the provider to whom we refer a beneficiary have to be participating with an MCO or an MHN?

MCOs – The provider must be a participant in the MCO. Contact the applicable MCO for a listing of providers in their network in your area.

MHNs – The PCPs may refer beneficiaries to any specialist for treatment However; the specialist must accept Medicaid beneficiaries.

5. What if we receive a request for a referral for a beneficiary we have never seen?

MCOs - PCPs cannot authorize specialty care for beneficiaries they have not seen. The Monthly Enrollment Report identifies new enrollees to the practice. PCPs are strongly encouraged to contact new enrollees and schedule a visit to establish a medical record.

MHNs - PCPs may, but are not required to, authorize specialty care for beneficiaries they have not seen. The Monthly Enrollment Report identifies new enrollees assigned to your practice. PCPs are strongly encouraged to contact new enrollees and schedule a visit to establish a medical record.

6. Is PCP authorization required each time a specialist sees an MCO or an MHN enrollee?

Unless the service you are providing is an exempt service, you must obtain authorization from the PCP for both the **MCO** and **MHN** programs. The length and scope of the authorization is at the discretion of the PCP. Call the managed care plan or the PCP for their authorization requirements.

7. Can referrals be made by telephone?

MCOs - Providers should contact the beneficiary's MCO to determine their policy on telephone referrals.

MHNs - PCPs may make referrals by telephone or in writing.

8. Do MCO and MHN enrollees admitted through the emergency room require PCP authorization?

Authorization may be required for admission to a hospital through the emergency department. The hospital should always check with the beneficiary's managed care plan for their authorization requirements. The hospital should contact the PCP or the MCO for authorization within 48 hours of the beneficiary's admission.

The physician component for inpatient services and specialist referrals for follow-up care after discharge from a hospital also require authorization.

9. Can enrollees change primary care providers?

Yes. Medicaid beneficiaries may contact their plan to change their PCP.

10. Can enrollees disenroll from their managed care plan?

- **Yes.** All beneficiaries may disenroll from their managed care plan during the first 90 days of their enrollment or re-enrollment period, or for "just cause" after the first 90

MANAGED CARE SUPPLEMENT

FAQs

days. Providers should refer to the MCO or MHN Policy and Procedures Guides for additional information concerning "just cause."

11. What should be done if a beneficiary is incorrectly enrolled with a PCP?

Providers should contact the beneficiary's MCO or MHN to rectify enrollment issues**.**

12. Are MCO and MHN enrollees responsible for copayments?

MCOs - MCOs have the option of requiring or not requiring copayments. Please check with the beneficiary's MCO for their current policy.

MHNs - All copayment requirements for MHNs were eliminated effective April 1, 2008. Providers should contact the beneficiary's MHN for additional information.

13. What if the beneficiary has a third-party insurance policy?

Medicaid will always be the payer of last resort whether FFS or a managed care program. If the beneficiary has private insurance, the carrier must be billed before billing Medicaid.

MCOs – MCOs have a Third-Party Liability (TPL) section that handles this recoupment. Providers, who are members of an MCO network, should contact the MCO for additional information.

MHNs – If the beneficiary states that he or she has other health insurance, bill the primary insurance before filing a claim to Medicaid. The Medicaid claim must show the carrier code, policy number, and any payment(s) received from the other health insurance. For detailed third-party liability claims filing information, refer to the Third-Party Liability Supplement of your Medicaid provider manual.

14. How should claims be filed when a PCP refers an enrollee to our office?

MCOs – Providers who participate in an MCO should follow the policies and procedures set by the MCO.

MHNs – Providers should file their claims as fee-for-service and include the referral number on the claim.

15. If my office has questions concerning claims, who should we contact?

MCOs – Providers who participate in an MCO network should contact the claims office of the MCO.

MHNs – Providers who participate in an MHN should contact the SCDHHS MHN Program Manager at (803) 898-4614.

16. Who do I contact at SCDHHS for additional questions or information?

Providers should contact the Department of Care Management at (803) 898-4614 and ask for the Program Manager assigned to the managed care plan about which you have questions.

MANAGED CARE SUPPLEMENT

FAQs

17. Which counties do Managed Care companies serve?

For information on the current counties served by MCOs, please visit the following Web sites:

Amerigroup	**www.myamerigroup.com**
BlueChoice Health Plan of South Carolina	**www.bluechoicesmedicaid.com**
Carolina Crescent Health Plan, Inc.	**www.carolinachp.com**
CHCares of South Carolina	**www.chcsouthcarolina.com**
First Choice	**www.selecthealthofsc.com**
Total Carolina Care	**www.totalcarolinacare.com**
Unison Health Plan	**www.unisonhealthplan.com**

18. Which counties does the MHN program serve?

For information on the current counties served by the MHN, please visit the following Web site:

South Carolina Solutions	**www.sc-solutions.org**

MANAGED CARE SUPPLEMENT

FAQs

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MANAGED CARE SUPPLEMENT

FORMS

SCHCC Beneficiary Enrollment Form (page 1)

South Carolina Healthy Connections Choices

Health Plan Enrollment

WEB FORM: Use this form to choose a health plan and doctor for each person in your family.

Four ways to enroll. You can:

1. Enroll on line at SCchoices.com, *or*
2. Call Healthy Connections Choices at 1-877-552-4642, and enroll by phone, *or*
3. Call Healthy Connections Choices and ask for an enrollment packet. The form in the packet will list the health plans in your county, and it will list the people in your family who can enroll. *Or,*
4. Fill out this web form. FAX it to 1-877-552-4672, or mail it to South Carolina Healthy Connections Choices, P.O. Box 8592, Columbia, SC 29202-8592.

For help, read the brochure, *Choosing a Health Plan,* and look at the health plan charts for your county to learn about choices you can make. (These are on the SCchoices.com website.) Or, call 1-877-552-4642.

✓ Who is the person filling out this form?

Name _____

Address _____

_____

✓ What is the best way to contact you? Cell phone, home phone, email, or other? Write the phone number, including area code, or the email address:

_____

✓ What language do you mostly speak at home?

☐ English ☐ Spanish ☐ Other _____

1. *Member name*

Birth date (month, day, year) *Medicaid ID*

Health plan (For plans to choose, see a chart for your county at SCchoices.com, or call 1-877-552-4642.)

Provider name (first, last) and provider address

OVER ➡

If you have questions, call South Carolina Healthy Connections Choices, 1-877-552-4642.

Call Monday to Friday, 8 a.m. to 6 p.m. TTY: 1-877-552-4670 .The call is free. Call for help in any language or to get this letter in Braille, on tape or in large type. Usted puede obtener este paquete de información en español.

MANAGED CARE SUPPLEMENT

FORMS

SCHCC Beneficiary Enrollment Form (page 2)

South Carolina Healthy Connections Choices

Health Plan Enrollment, *WEB FORM, page 2*

2. *Member name*

Birth date (month, day, year) *Medicaid ID*

Health plan (For plans to choose, see a chart for your county at SCchoices.com, or call 1-877-552-4642.)

Provider name (first, last) and provider address

3. *Member name*

Birth date (month, day, year) *Medicaid ID*

Health plan (For plans to choose, see a chart for your county at SCchoices.com, or call 1-877-552-4642.)

Provider name (first, last) and provider address

4. *Member name*

Birth date (month, day, year) *Medicaid ID*

Health plan (For plans to choose, see a chart for your county at SCchoices.com, or call 1-877-552-4642.)

Provider name (first, last) and provider address

COPY THIS PAGE IF YOU NEED MORE SPACE TO WRITE

✓ Mail this form to South Carolina Healthy Connections Choices, P.O. Box 8592, Columbia, SC 29202-8592, or fax the form to 1-877-552-4672.

✓ You can also enroll by phone at 1-877-552-4642, or on our website at www.SCchoices.com.

If you have questions, call South Carolina Healthy Connections Choices, 1-877-552-4642.

Call Monday to Friday, 8 a.m. to 6 p.m. TTY: 1-877-552-4670. The call is free. Call for help in any language or to get this letter in Braille, on tape or in large type. Usted puede obtener este paquete de información en español.

MANAGED CARE SUPPLEMENT

FORMS

SCHCC Beneficiary Voluntary Disenrollment Form (page 1)

South Carolina Healthy Connections Choices

Request to Return to Fee-for-Service Medicaid

Use this form if you want to switch to Fee-for-Service Medicaid and you have been in your health plan for more than 90 days. Before 90 days, you can request by phone, at 1-877-552-4642.

✓ Who is the person filling out this form?

Name _____

Address _____

_____

✓ What is the best way to contact you? Cell phone, home phone, email, or other? Write the phone number, including area code, or the email address:

_____

✓ What language do you mostly speak at home?

☐ English ☐ Spanish ☐ Other _____

1. **P1_Member_Name,** P1_Member_DOB Medicaid ID: P1_Member_ID

➡ Current plan: P1_Health_Plan_Name

➡ **Reason the member wants to leave the plan.** *Put an X in the box or boxes that show reasons.*

☐ Moved out of plan service area ☐ In jail ☐ Got poor quality care
☐ Can't get needed services ☐ Plan doesn't offer coordinated services that member needs
☐ Plan does not cover certain services because of moral or religious reasons
☐ Other _____

_____

2. **P2_Member_Name,** P2_Member_DOB Medicaid ID: P2_Member_ID

➡ Current plan: P2_Health_Plan_Name

➡ **Reason the member wants to leave the plan.** *Put an X in the box or boxes that show reasons.*

☐ Moved out of plan service area ☐ In jail ☐ Got poor quality care
☐ Can't get needed services ☐ Plan doesn't offer coordinated services that member needs
☐ Plan does not cover certain services because of moral or religious reasons
☐ Other _____

_____

OVER ➡

If you have questions, call South Carolina Healthy Connections Choices, 1-877-552-4642.
Call Monday to Friday, 8 a.m. to 6 p.m. TTY: 1-877-552-4670. The call is free. Call for help in any language or to get this letter in Braille, on tape or in large type. Usted puede obtener este paquete de información en español.

MANAGED CARE SUPPLEMENT

FORMS

SCHCC Beneficiary Voluntary Disenrollment Form (page 2)

South Carolina Healthy Connections Choices — Request to Return to Fee-for-Service Medicaid, *page 2*

3. **P3_Member_Name,** P3_Member_DOB Medicaid ID: P3_Member_ID

➨ Current plan: P3_Health_Plan_Name

➨ **Reason the member wants to leave the plan.** *Put an X in the box or boxes that show reasons.*

☐ Moved out of plan service area ☐ In jail ☐ Got poor quality care
☐ Can't get needed services ☐ Plan doesn't offer coordinated services that member needs
☐ Plan does not cover certain services because of moral or religious reasons
☐ Other _____

_____

4. **P4_Member_Name,** P4_Member_DOB Medicaid ID: P4_Member_ID

➨ Current plan: P4_Health_Plan_Name

➨ **Reason the member wants to leave the plan.** *Put an X in the box or boxes that show reasons.*

☐ Moved out of plan service area ☐ In jail ☐ Got poor quality care
☐ Can't get needed services ☐ Plan doesn't offer coordinated services that member needs
☐ Plan does not cover certain services because of moral or religious reasons
☐ Other _____

_____

5. **P5_Member_Name,** P5_Member_DOB Medicaid ID: P5_Member_ID

➨ Current plan: P5_Health_Plan_Name

➨ **Reason the member wants to leave the plan.** *Put an X in the box or boxes that show reasons.*

☐ Moved out of plan service area ☐ In jail ☐ Got poor quality care
☐ Can't get needed services ☐ Plan doesn't offer coordinated services that member needs
☐ Plan does not cover certain services because of moral or religious reasons
☐ Other _____

_____

✓ Mail this form in the return envelope, or fax the form to 1-877-552-4672.

If you have questions, call South Carolina Healthy Connections Choices, 1-877-552-4642.
Call Monday to Friday, 8 a.m. to 6 p.m. TTY: 1-877-552-4670. The call is free. Call for help in any language or to get this letter in Braille, on tape or in large type. Usted puede obtener este paquete de información en español.

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Plan Initiated Disenrollment Request

The member(s) listed below is to be disenrolled from the following plan _____ for the reason listed below. Please check all that apply.

- ☐ Member demonstrates a pattern of disruptive abusive behavior that could be construed as non-compliant and is not caused by a presenting illness;
- ☐ Member's utilization of services is fraudulent or abusive;
- ☐ Member is in a long-term care nursing facility beyond (30) calendar days;
- ☐ Member is placed in an intermediate care facility for the mentally retarded (ICF/MR);
- ☐ Member moved out of the service area and plan does not operate in the new service area;
- ☐ Member has died or is incarcerated.
- ☐ Other _____

Print the Name of Member to be Disenrolled (Last, First, Middle Initial)	Birth Date	Medicaid ID Number or Social Security Number	Requested Disenrollment Date

Address	Phone Number
c/o _____	(_____) _____
Street _____	County _____
City/State/Zip _____	

Signature: _____ Date: _____

The South Carolina Department of Health and Human Services will determine if the Health Plan has shown a good cause to disenroll the Medicaid member. The Health Plan Liaison will give written notification to the Health Plan of the decision. Medicaid members have the right to appeal enrollment and disenrollment decisions with the South Carolina Department of Health and Human Services.

The Health Plan shall not discriminate against any Medicaid member on the basis of their health status, need for health care services or any other adverse reason with regard to the member's health, race, sex, handicap, age, religion or national origin.

Mail completed form to: South Carolina Healthy Connections Choices
Attn: Larissa Hendley
140 Stoneridge Drive, Suite 385
Columbia, SC 29210

MANAGED CARE SUPPLEMENT

FORMS

MHN Primary Care Provider Reassignment Form

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
MANAGED CARE PLAN CHANGE FORM
For Use by Members Only

I wish to change from the Managed Care Program I am currently in and join a new Managed Care Program or return to Regular Medicaid. ***Please complete all sections of this form.***

Please **DISENROLL** me from the following plan (check one):		Please **ENROLL** me in the following plan (check one):	
□First Choice (HM1000)	□South Carolina Solutions (PCM120)	□First Choice (HM1000)	□South Carolina Solutions (PCM120)
□Unison (HM1600)	□Palmetto Medical Home Network (PCM130)	□Unison (HM1600)	□Palmetto Medical Home Network (PCM130)
□Upstate Carolina Best Care (PCM100)	□PEP	□Upstate Carolina Best Care (PCM100)	□_____
□ PhyTrust of South Carolina (PCM110)	□ _____	□PhyTrust of South Carolina (PCM110)	□Regular Medicaid
My current doctor is _____		*My new doctor is* _____	

I want to change plans because of the following reason (Check the one reason that best describes your problem): ***Reasons to support your request are necessary. Please give your reasons on the bottom of this form. If reasons are not given, your request may not be honored.***

☐ I am receiving poor quality care. (31)	☐ I am not able to get the care I need. (33)	☐ Access to care issues (Plan doctor too far away for me to get to). (32)
☐ I have moved outside service area. (30)	☐ My doctor/my specialist/my pharmacy is not part of the network. (35)	☐ I can't get the medicines I used to get with regular Medicaid. (39)
☐ I am entering a waiver program. (37) Circle one: CLTC or MFCP	☐ I need hospice services or am entering a nursing home. (38)	☐ The doctor I was assigned to does not know or understand my health care needs. (36)
☐ Plan staff is rude and won't help me. (41)	☐ I didn't realize what I was signing up for. (52)	☐ It takes too long to get services approved. (34)
☐ I'm unhappy with the doctor. (51)	☐ I'm unhappy with the plan. (50)	☐ I have changed my mind (1st 90 days only). (52)
☐ Other: _____		

PRINT THE NAME OF EACH FAMILY MEMBER–(LAST, FIRST, MIDDLE INITIAL)	BIRTH DATE	MEDICAID ID NUMBER

ADDRESS WHERE I GET MY MAIL: _____ **CITY:**_____ **STATE**_____ **ZIP**_____

PHONE NUMBER or CELL where I can be reached: (_____)_____ **COUNTY I LIVE IN** _____
Area Code

ADDRESS WHERE I LIVE (if different from where you get your mail): _____

I certify that I have legal custody of any minor children listed on this Change Form and have the authority to make health care decisions on their behalf.

Name (Please Print): _____ **Signature:** _____ **Date:** _____

DHHS Form 280-2 (10/06)

MANAGED CARE SUPPLEMENT

FORMS

Sample of Hospital Admission Agreement/Formal Arrangement

MEDICAL HOMES NETWORK

SCDHHS, P.O. Box 8206, Columbia, SC 29202-8206, Phone (803) 898-2818

South Carolina MHN Hospital Admission Agreement/Formal Arrangement
This form is to be completed in lieu of having hospital admitting privileges.

SC MHN Primary Care Provider Applicant
(First Party Section)

Applicant Name:_____ Provider Number: _____

Group Name: _____

Mailing Address: _____

To ensure a complete understanding between both parties and continuity of coverage among providers, SC MHN has adapted the SC MHN Patient Admission Agreement/Formal Arrangement Form. This form serves as a formal written agreement established between the above parties for the following:

- The SC MHN Primary Care Provider is privileged to refer adult/pediatric and Emergency patients to the second party for hospital admission. The second party is agreeing to treat and administer to the medical needs of these patients while they are hospitalized.
- The second party will arrange coverage for SC MHN member admissions during his/her vacation.
- This agreement may be terminated by either of the parties at any time by giving written 30 days advance notice to the other party or by mutual agreement.
- The SC MHN Primary Care Provider will notify SC MHN in writing of any changes/terminations to this agreement.
- The SC MHN Primary Care Provider will provide the second party with the appropriate payment authorization number.

Physician and/or Group Agreeing to Cover Hospital Admissions For Above SCMHN Provider Applicant:
(Second Party Section)

Physician/Group Name: _____

Mailing Address: _____

_____ Phone Number: _____

Specialty: _____ Ages Admitted: _____

Hospital Affiliation(s) and Location(s): _____

_____

Signature: _____ Date: _____

MANAGED CARE SUPPLEMENT

FORMS

SAMPLE WIC REFERRAL FORM

PL103-448, §204(e) requires States using managed care arrangements to serve their Medicaid beneficiaries to coordinate their WIC and Medicaid Programs. This coordination should include the referral of potentially eligible women, infants, and children and the provision of medical information to the WIC Program. To help facilitate the information exchange process, please complete this form and send it to the address listed below. Thank you for your cooperation. .

Name of Person being referred: _____

Address: _____

Phone: _____

The following classifications describe the populations served by the WIC program. Please check the category that most appropriately describes the person being referred:

____ Pregnant woman

____ Woman who is breast feeding her infant(s) up to one year postpartum

____ Woman who is non-breast feeding up to six months postpartum

____ Infant (age 0-1)

____ Child under age 5

States may consider using this space to either include specific medical information or to indicate that such information can be provided if requested by the WIC Program.

Provider's Name: _____

Provider's Phone: _____

I, the undersigned, give permission for my provider to give the WIC Program any required medical information.

_____

(Signature of the patient being referred or, in the case of children and infants, signature and printed name of the parent/guardian)

Send completed form to:

WIC Program Contact
Address
Phone Number

MANAGED CARE SUPPLEMENT

FORMS

SAMPLE MEDICAL RECORD RELEASE

I, the undersigned, give permission for my provider, acting on my behalf, to refer my name for WIC services and to release necessary medical record information to the WIC agency.

Signature _____
(signature of patient being referred or, in case of children and infants, the signature and printed name of the parent/guardian)

Date _____

MANAGED CARE SUPPLEMENT

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