Healthy Connections *Visual*
MEDICAID BASICS BOOK

❯ Managed Care

An illustrated companion to the interactive courses at: MedicaideLearning.com.

SOUTH CAROLINA
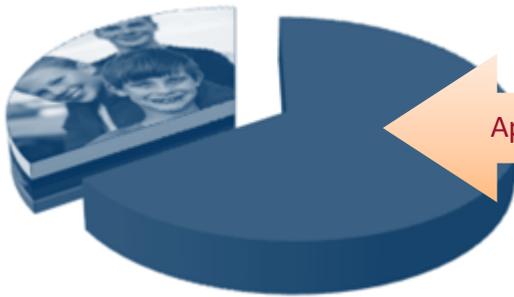Healthy Connections
MEDICAID

Contents

Why Managed Care?

In 2014, Medicaid payments equaled approximately $6 billion. Federal funds match 70% of every dollar.

South Carolina
Puts up **30** cents/dollar

Federal government
Matches **70** cents/dollar

Other interesting facts:

Approx. **60%** of Medicaid members are **age 0 to 18**.

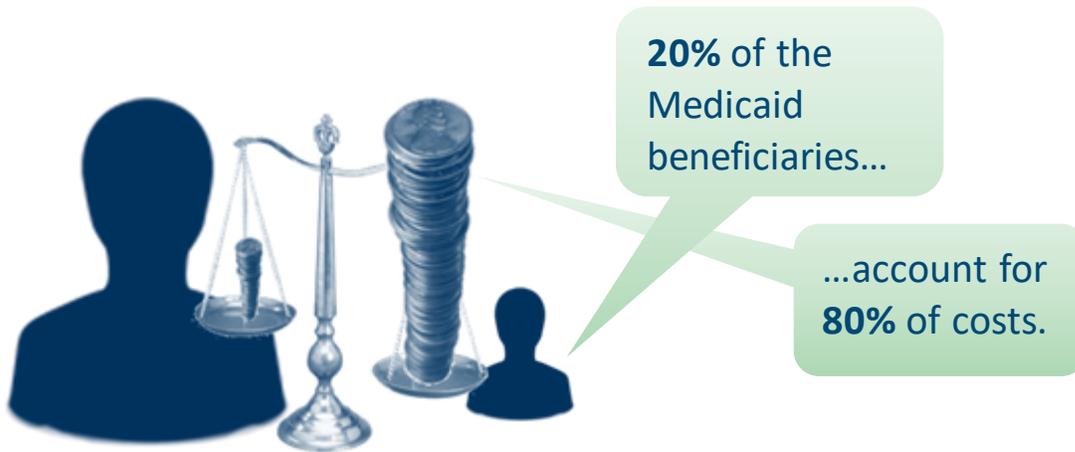Approx. **60%** of all **children** in SC are on Medicaid.

Medicaid pays for approx. **60%** of all **births** in SC.

Medicaid pays for approx. **85%** of **teen births** in SC.

Unsustainable Growth

20% of the Medicaid beneficiaries...

...account for **80%** of costs.

Money being spent & the # of enrollees are increasing...

Evolution of Managed Care

To better meet the needs of the beneficiaries...

1996 · 1st Managed Care plan

- First Choice by Select Health
- Began operating December **1996**
- Maintained its presence in the state
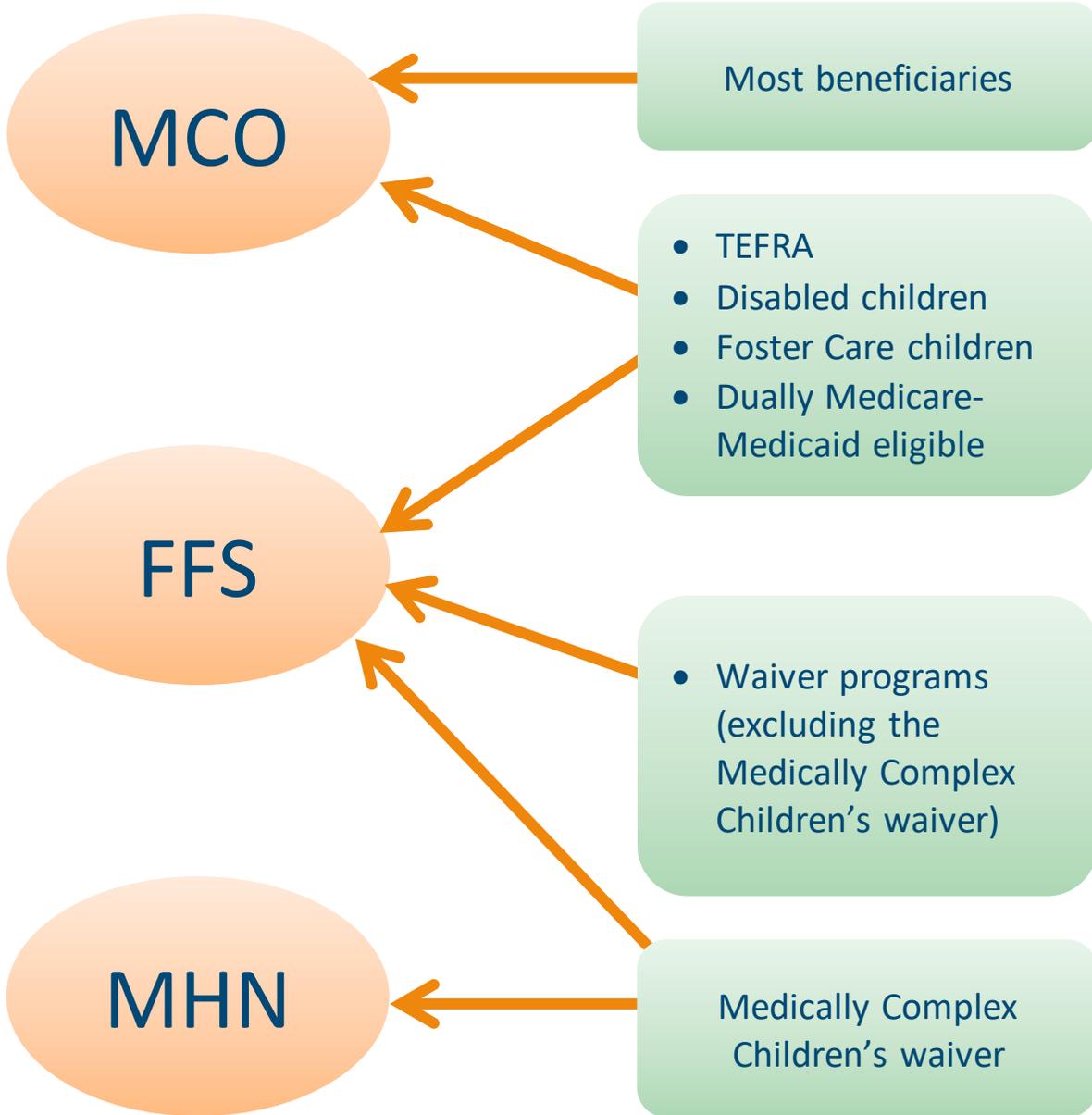- *But was a relatively small program compared to FFS...*

Enrollment Counselors · MHNs · MCOs

- The state adapted to enhance managed care.
- To retain a full array of benefits, they added:
  - an **enrollment counselor** program
  - **medical homes network** programs
  - more **managed care organizations**

The overall goal is to get beneficiaries better established in a stable medical home.

Plan Eligibility

Most beneficiaries must choose a Managed Care Organization (MCO). Certain beneficiaries may opt for Fee-For-Service (FFS) or a Medical Home Network (MHN).

MCO ← Most beneficiaries

MCO ←
- TEFRA
- Disabled children
- Foster Care children
- Dually Medicare-Medicaid eligible

FFS ←
- TEFRA
- Disabled children
- Foster Care children
- Dually Medicare-Medicaid eligible

FFS ←
- Waiver programs (excluding the Medically Complex Children's waiver)

FFS ← Medically Complex Children's waiver

MHN ← Medically Complex Children's waiver

Plans Chart

	Fee-for-Service (FFS)	Medical Home Networks (MHN)	Managed Care Organization (MCO)
Benefits	- Traditional coverage plan - Medically necessary services - Limits & waivers may apply (see below)	May include: - Nurse advice line · care coordination - Health management programs - Adult dental · adult vision *For health plan specifics:* www.scchoices.com.	
Providers	Any provider that accepts Medicaid	Primary care providers (PCPs) network (no specialists)	Contracts with: - primary and specialty care providers - hospitals, pharmacies, DME providers, etc.
ID card	Healthy Connections	Healthy Connections	- Healthy Connections - Plus additional MCO card
Prior Authorization	- Certain items/ procedures - Example: DME - Provider manuals (Section 2)	1. Confirm eligibility. 2. Get the PCP's name. 3. Call PCP for their 6-digit referral number.	- Most services require MCO authorization. - Providers may exempt PA services during contract negotiations.
Copay	- Varies according to service type - Co-pay schedule: provider manuals (Appendix 3)	- Varies according to service type - Co-pay schedule: provider manuals (Appendix 3)	Depends on the health plan
Claims Processing	By SCDHHS	By SCDHHS (FFS manner)	By the health plan

Waiver

A beneficiary may be approved only for certain, specific services, indicated by their waiver.

Full Medicaid + additional benefits

- Head and Spinal Cord Injury (HASCI) Waiver
- Intellectually Disabled/Related Disability Waiver
- Pervasive Developmental Disorder Waiver
- Community Supports Waiver
- Community Choices Waiver
- Mechanical Ventilation Waiver
- HIV/AIDS waiver
- Medically Complex Children's Waiver

Only approved for certain services

- Healthy Connections Checkup (Family Planning)

Limits

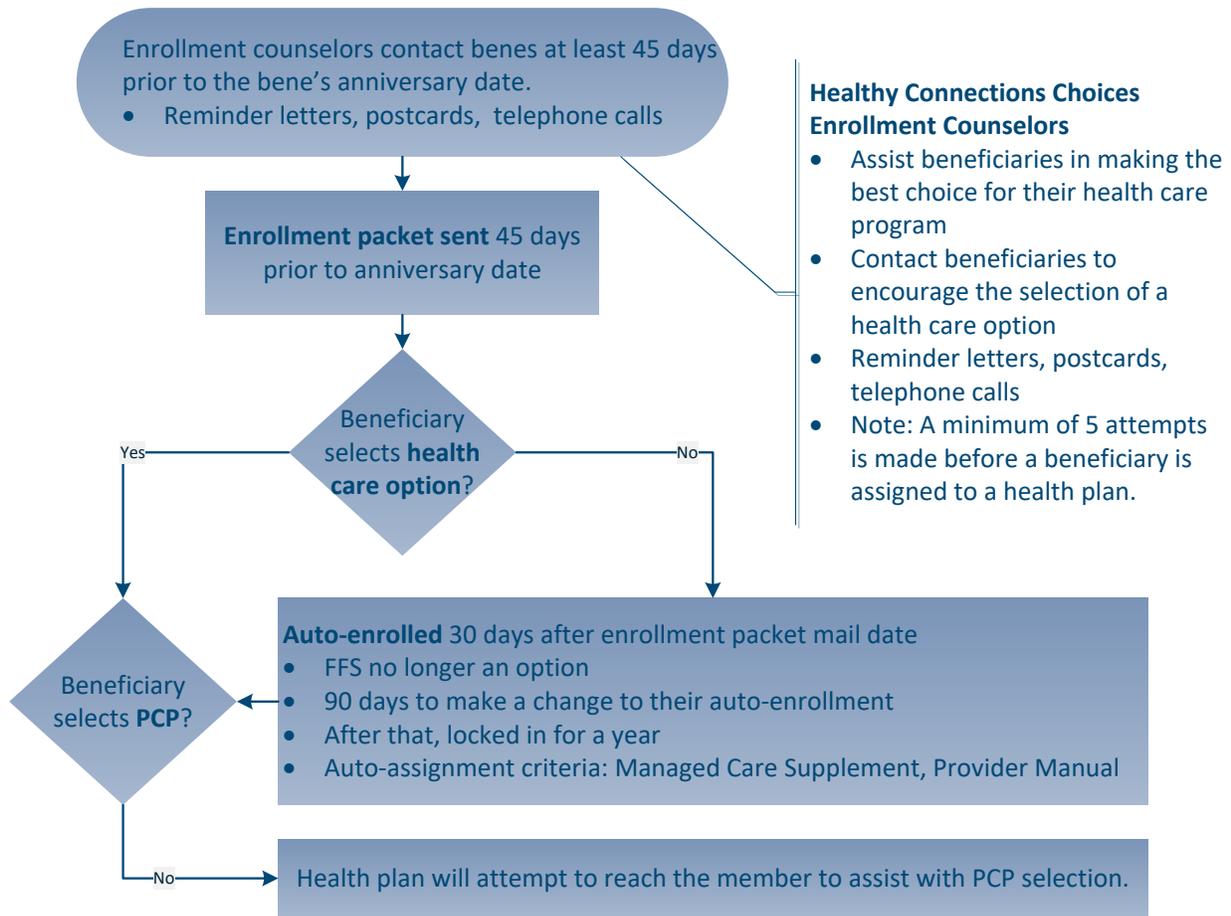Some services have limits during the state fiscal year (July 1 – June 30). *Examples:*

Service	Coverage limitation
Psychiatric & Counseling Services	12 mental health visits per fiscal year
Chiropractic Services	6 chiropractic visits per fiscal year
Adult physical exams	Once every 2 years (ages 21 & up)

More on service limitations: Provider Manuals, Section 2

SC Healthy Connections Choices (SCHCC)

SCHCC handles all enrollment and disenrollment requests & assists eligible beneficiaries select their Medicaid service delivery system.

Enrollment counselors contact benes at least 45 days prior to the bene's anniversary date.
- Reminder letters, postcards, telephone calls

Enrollment packet sent 45 days prior to anniversary date

Beneficiary selects **health care option**?

Yes — No

Healthy Connections Choices Enrollment Counselors
- Assist beneficiaries in making the best choice for their health care program
- Contact beneficiaries to encourage the selection of a health care option
- Reminder letters, postcards, telephone calls
- Note: A minimum of 5 attempts is made before a beneficiary is assigned to a health plan.

Beneficiary selects **PCP**?

Auto-enrolled 30 days after enrollment packet mail date
- FFS no longer an option
- 90 days to make a change to their auto-enrollment
- After that, locked in for a year
- Auto-assignment criteria: Managed Care Supplement, Provider Manual

No —

Health plan will attempt to reach the member to assist with PCP selection.

Contacting SCHCC

Beneficiaries are encouraged to contact SCHCC to enroll in a health plan.

Mail or **fax** a completed enrollment form.

Meet with an enrollment counselor at a scheduled **community meeting** or at a **personal appointment**.

Call SCHCC at 877-552-4642.

Visit www.SCchoices.com

Failure to contact SCHCC or respond to the mailings may result in auto-assignment to a health plan.

Provider Choice

Providers can choose to participate in several ways.

Medical Home Network
- Patients: MHN eligible
- Payment: FFS manner

Medicaid provider
- Bill SCHC beneficiaries only

Managed Care Organization
- Contract with one or more MCOs
- Optional enrollment as a SC Medicaid provider
- Bill directly to the plan
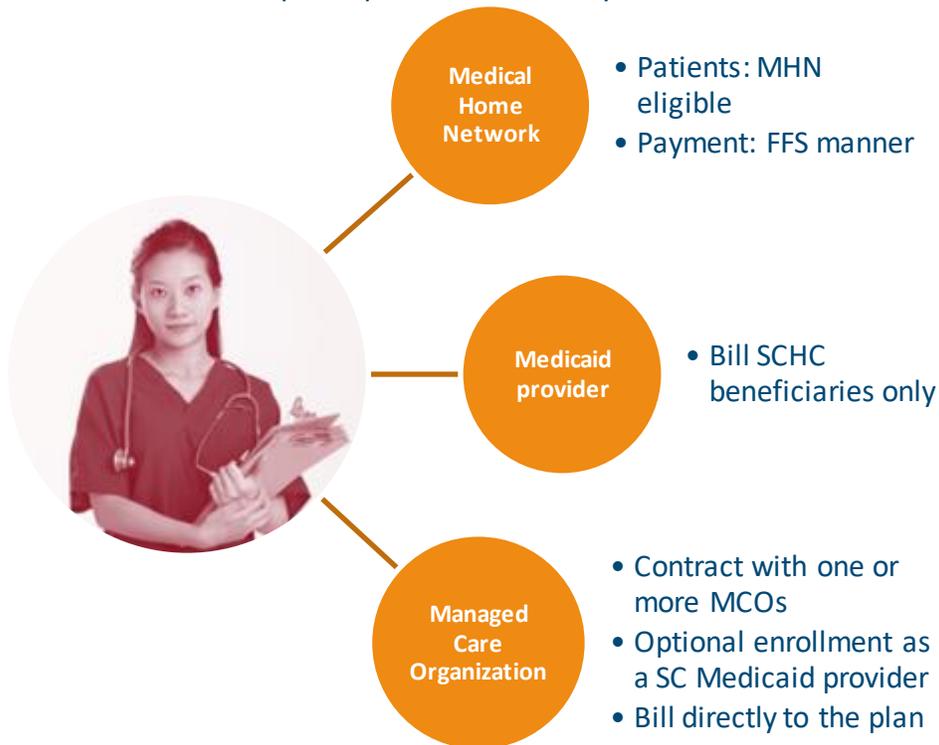
Lastly, you can choose to participate in all or a combination of the three delivery systems.

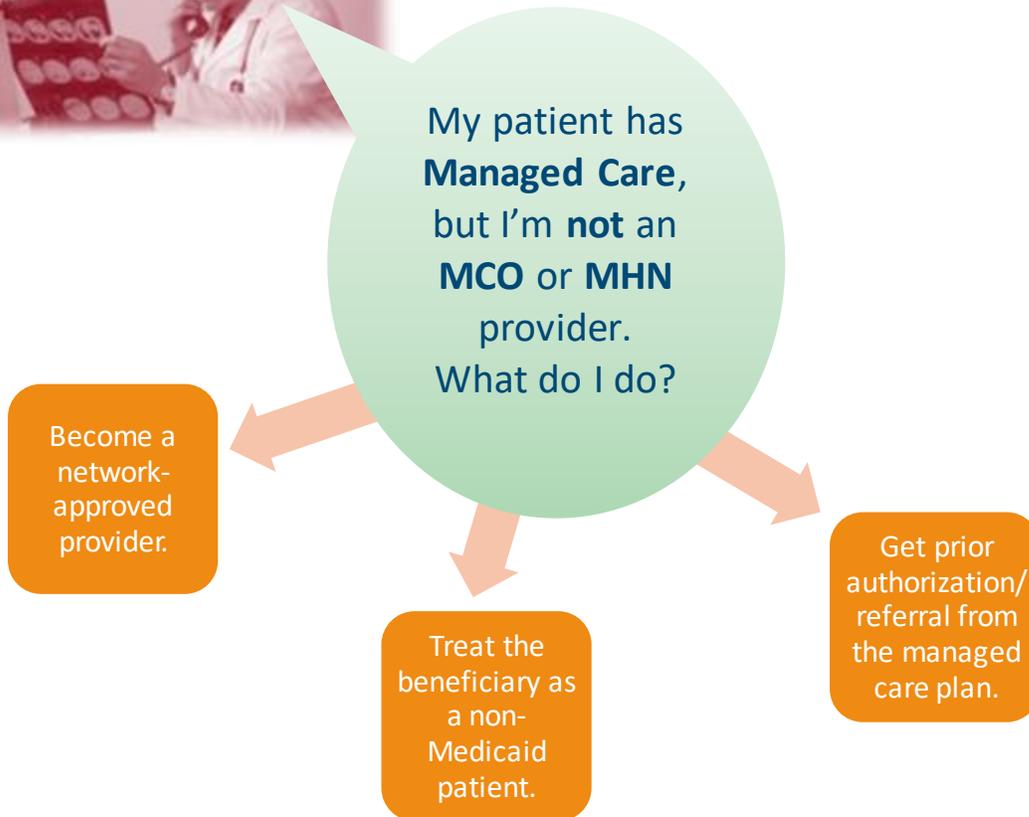## *Managed Care Enrollees*

How much of your patient load is Medicaid?

Approx. **60%** of our eligible population has a managed care plan.

Managed care enrollment in *your* county? (www.scdhhs.gov)

Prior Authorization (PA)

My patient has **Managed Care**, but I'm **not** an **MCO** or **MHN** provider. What do I do?

Become a network-approved provider.

Treat the beneficiary as a non-Medicaid patient.

Get prior authorization/ referral from the managed care plan.

Failure to obtain PA prior to rendering services

- May result in non-payment
- Managed Care program staff will intervene
  - but may not "force" a health plan to reimburse for services
- Keep in mind that becoming a network provider is not an immediate process.

Managed Care Supplement? Click here for provider manual.

Expected Impact on Care

Controlled growth

Coordination of services

More appropriate use of health care services

Less duplication of services for members

More competitive environment

Improved delivery for Medicaid beneficiaries