Managed Care in South Carolina

This profile reflects state managed care program information as of August 2014, and only includes information on active federal operating authorities, and as such, the program start date may not reflect the earliest date that a program enrolled beneficiaries and provided services. Some states report populations and services available to program participants under the federal authority (e.g. Section 1115 waiver), so these features cannot be easily distinguished for each program.

Overview of Current Managed Care Programs

In 2011, all Medicaid beneficiaries in South Carolina were in some form of managed care. South Carolina has been operating managed care since 1996 through its comprehensive risk-based **managed care organization (MCOs)** program, which serves certain children, pregnant women and non-dually eligible adults with disabilities, and covers acute, primary, and some specialty care services, and outpatient behavioral health. Initially, MCOs were available on a voluntary basis. Between 2006 and 2007, the state introduced the **Medical Homes Network (MHN)** program, a statewide enhanced primary care case management program (PCCM), that utilizes networks of primary care providers to provide and arrange for most Medicaid acute, primary, and specialty care, and behavioral health for most Medicaid participants in the state who can enroll on a voluntary basis (excludes those in another managed care program, receiving home and community based waiver services, or residing in a institution). In September 2013, the state transitioned from the PCCM program to a MCO service delivery system. Enrollment in managed care in the state remained limited until 2006, when the state also introduced the Healthy Connections Choices program, which deployed enrollment counselors to help beneficiaries who were required to choose one of the three Medicaid delivery models available in the state: an MCO, the new PCCM program, or the traditional fee-for-service (FFS) option. That year, the state also supplemented its primary managed care programs by introducing (1) a **Program of All-Inclusive Care for the Elderly (PACE)**, which provided all Medicare and Medicaid services, including long term care services, to individuals over age 55 who meet a nursing home level of care, and (2) a **Non-emergency Transportation** program for most Medicaid beneficiaries statewide.

In 2011, the state further expanded managed care through its Healthy Connections Choices program when it began enrolling additional Medicaid beneficiaries formerly served in the FFS system in either the MCO program or the Medical Homes Network Program on a mandatory basis; however, children in foster care and with certain disabilities, Medicaid waiver enrollees, certain people served in institutions, and dual-eligible beneficiaries remained exempt from mandatory managed care. The state has also recently added or “carved in” inpatient behavioral health services to the MCO benefit package and, as of October 2013, expanded mandatory managed care to all children under the age of one.

Participating Plans, Plan Selection, and Rate Setting

The state contracts with four managed care plans to provide services to MCO enrollees. These include **two national, for-profit plans** (Absolute Total Care (owned by Centene) and UnitedHealthcare Community Plan (formerly Unison)), **one local, for-profit plan,** (BlueChoice Health Plan), and **one national, not-for-profit plan** (First Choice by Select Health). The state also contracts with three physicians networks (Carolina Medical Homes, Palmetto Physician Connections, and South Carolina Solutions) to coordinate care through its MHN program. The state selects plans through competitive procurement process and sets rates through an administrative process using actuarial analyses that accounts for differences in cost by age, gender, eligibility category, and health status.

Quality and Performance Incentives

South Carolina monitors MCO and PCCM quality by requiring plans or networks to submit a number of quality measures, including HEDIS and CAHPS. To encourage quality in MCOs, the state uses both withholds and performance incentives. In 2012, the state withheld 1% from capitation payments and allowed MCOs that improved their quality measurement score by one standard deviation on 10 measurements to receive a bonus payment; in 2013, the state increased the withhold to 1.5% and required improvement on 16 measures. Between 2012 and 2013, the state also set aside an additional 1% of capitation payments for incentives related to patient centered medical home enrollment and birth outcomes. Additionally, the state employs an auto-assignment algorithm to direct beneficiaries to MCO plans that have higher quality and better performance on quality measures. The state requires MHNs attain accreditation by a national accreditation body, such as the National Committee for Quality Assurance. The state may also impose liquidated damages, sanctions and/or restrict enrollment if a MHN does not provide acceptable quality of care.

Table: Managed Care Program Features, as of August 2014

Program Name	South Carolina Health Maintenance Program (HMO)	Program for the All-Inclusive Care for the Elderly (PACE)	Non-Emergency Transportation Program
Program Type	MCO	PACE	Transportation PAHP
Program Start Date	August 1996	November 2003	May 2007
Statutory Authorities	1932(a)	PACE	1902(a)(70)
Geographic Reach of Program	Select Counties	Select Regions	Statewide
Aged		X	X
Disabled Children & Adults	X	X (age 55+)	X
Children	X		X
Low-Income Adults	X		X
Medicare-Medicaid Eligibles ("duals")		X (age 55+)	X
Foster Care Children			X
American Indians/ Alaska Natives			X
Mandatory or Voluntary enrollment?	Mandatory	Voluntary	Mandatory
Medicaid Services Covered in Capitation (*Specialized services other than those listed may be covered. Services not marked with an X are excluded or "carved out" of the benefit package.)*			
Inpatient hospital	X	X	
Primary Care and Outpatient services	X	X	
Pharmacy	X	X	
Institutional LTC		X	
Personal Care/HCBS	X	X	
Inpatient Behavioral Health Services		X	
Outpatient Behavioral Health Services	X	X	
Dental		X	

Program Name	South Carolina Health Maintenance Program (HMO)	Program for the All-Inclusive Care for the Elderly (PACE)	Non-Emergency Transportation Program
Transportation	X	X	X
Participating Plans	1. Absolute Total Care 2. BlueChoice Health Plan 3. First Choice by Select Health of South Carolina, Inc. 4. United HealthCare	1. Palmetto SeniorCare 2. The OAKS PACE	1. Logisticare 2. Medical Transportation Management (MTM)
Uses HEDIS Measures or Similar	X	NA	
Uses CAHPS Measures or Similar	X	NA	
State requires MCOs to submit HEDIS or CAHPS data to NCQA	X	NA	NA
State Requires MCO Accreditation	X	NA	NA
External Quality Review Organization	Carolinas Center for Medical Excellence		
State Publicly Releases Quality Reports	Yes		

Sources: Centers for Medicare and Medicaid Services (CMS), National Summary of State Medicaid Managed Care Programs as of July 1, 2011.

Kaiser Commission on Medicaid and the Uninsured. Profile of Medicaid Managed Care Programs in 2010. September 2011.

National Committee on Quality Assurance. NCQA Medicaid Managed Care Toolkit 2012 Health Plan Accreditation Standards. State Use of Accreditation as of February 2012.

Notes: Managed Care Organization (MCO); Prepaid Inpatient Health Plans (PIHP); Prepaid Ambulatory Health Plan (PAHP); Mental Health/Substance Use Disorder (MH/SUD); Healthcare Effectiveness Data and Information Set (HEDIS); Consumer Assessment of Healthcare Providers and Systems (CAHPS).

Primary Care and Outpatient Services include physician services, hospice, laboratory, imaging, FQHC, and other specialty services delivered in outpatient offices and clinics. Institutional Long Term Care (LTC) includes Skilled Nursing Facilities (SNF) and/or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IDD).

External Quality Review Organization activities are only required for MCOs, PIHPs, PAHPs, and other applicable entities with comprehensive risk contracts.