

MCO Carve In: Nursing Home Questions/Answers

Dated 1/6/26

Question #	Nursing Facility Comments	Nursing Facility Question	SCDHHS Answer
1	We had over 649 auto enrollments as of 01.01.26, and I am sure there will be some that were missed or that showed up after the eligibilities were ran.	Will the Plans be required to give retro auth for any that were missed?	<p>Nursing facility services are not carved into Medicaid managed Care, therefore authorizations and payments will remain a Medicaid FFS responsibility.</p> <p>Furthermore, as of 1/1/26, nursing homes will no longer need to bill Medicaid managed care plans for the first 90 days of Medicaid skilled nursing facility services.</p>
2	Of the 649 enrollments, 489 were enrolled with Humana Med even though there was a large portion of them already in Nursing Home Pay Category.	Will there be a dis-enrollment process for those patients, as the Humana plans do not appear to be Prime/Dual? And Humana Med historically only pays for 90 days	<p>All Medicaid members over the age of 18 and enrolled in both Medicare and Medicaid as well as individuals enrolled in community choices, HIV or the vent home and community based waiver and individuals residing in a nursing facility were enrolled in a Medicaid Managed care plan effective January 1, 2026.</p> <p>The Dual/Prime program sunsetted on 12/31/25, per Federal CMS instructions and those individuals were transitioned to a new Dual Special Needs Medicare Plan. As part of this transition, we unwound nursing facility services from that managed care environment and returned it to FFS Medicaid.</p> <p>Individuals residing in a nursing home that are now enrolled in a managed care plan will have access to case management services, additional benefits, and only medical services (e.g. hospital services) will be reimbursed by the MCO.</p>

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3	A few of the patients were already enrolled in Hospice , which normally takes them out of an HMO like Humana	How will those be handled?	Our system now allows individuals enrolled in Hospice to continue to receive hospice services via FFS Medicaid but continue to allow the individual to remain in the home and community-based waiver program and/or the MCO.
4		Will the Plans be held to the same standards as traditional Medicaid FFS, at least be held to following the same processes, as they currently do not. In regards to Auths, bed holds, complex guidelines. Enrolling a Med Complex in a plan adds a lot more follow-up to the case mgrs., and none of the plans follow the same processes.	Nursing facility services are not carved into Medicaid managed Care, therefore authorizations and payments will remain a Medicaid FFS responsibility. Furthermore, as of 1/1/26, nursing homes will no longer need to bill Medicaid managed care plans for the first 90 days of Medicaid skilled nursing facility services.
5	Initial auth - 90 day approval- then typically drop auth- wants patient disenrolled after 90 days	Question is - will patients revert back to FFS or stay managed by Humana and review auths every 3 months? Will they follow SC DHHS guideline for Complex?	Nursing facility services (including complex care or nursing home vent) are not carved into Medicaid managed Care, therefore authorizations and payments will remain a Medicaid FFS responsibility. Furthermore, as of 1/1/26, nursing homes will no longer need to bill Medicaid managed care plans for the first 90 days of Medicaid skilled nursing facility services.
6	Medicaid Plans- only auth for 30 days	Will these become uniform with the state policies with complex? They do	Nursing facility services (including complex care or nursing home vent) are not carved into Medicaid
7	Dual Plans- auth for 1 year		

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8	Complex plans- only auth 7 days at a time- review like skilled- if the patient doesn't have two qualifiers they will drop to custodial- NOT following the SC DHHS guidelines!	not recognize BMI as a standalone qualifier even though the state has it outlined in their policy.	managed Care, therefore authorizations and payments will remain a Medicaid FFS responsibility. Furthermore, as of 1/1/26, nursing homes will no longer need to bill Medicaid managed care plans for the first 90 days of Medicaid skilled nursing facility services.
17		Our organization does not have contracts with the various Medicaid MCOs. What impact will this have?	None. Nursing facility services (including complex care or nursing home vent) are not carved into Medicaid managed Care, therefore authorizations and payments will remain a Medicaid FFS responsibility. Furthermore, as of 1/1/26, nursing homes will no longer need to bill Medicaid managed care plans for the first 90 days of Medicaid skilled nursing facility services.

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18		What impact will this change have on delivery of Part B therapy services for residents in a Medicaid stay?	<p>None.</p> <p>Nursing facility services (including complex care or nursing home vent) are not carved into Medicaid managed Care, therefore authorizations and payments will remain a Medicaid FFS responsibility.</p> <p>Furthermore, as of 1/1/26, nursing homes will no longer need to bill Medicaid managed care plans for the first 90 days of Medicaid skilled nursing facility services.</p> <p>SCDHHS also does not authorize nor reimburse Medicare services and nursing facilities should continue normal billing practices with FFS Medicare.</p>
19		Will there be changes to the TAD, or will Medicaid billing continue as normal? Historically MCOs have not been included on the TAD.	No.
20		Will the MCO's ever transition into PRIME plans? If so, that will effect the members Medicare. Are PRIME plans going away?	Prime ended on December 31, 2025. Nursing homes previously billing Prime plans for Medicaid nursing facility days should start billing FFS Medicaid for service dates beginning on January 1, 2026.
21		The residents who are currently enrolled in PRIME plans, if the PRIME plans go away, will they just transition back to traditional Medicare?	The Dual/Prime program sunsetted on 12/31/25, per Federal CMS instructions and those individuals were transitioned to a new Dual Special Needs Medicare Plan effective January 1, 2026. As part of this transition, we unwound nursing facility services from that managed care environment and returned it to FFS Medicaid.

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22		If someone misses enrollment due to hospital stay and they are auto enrolled in a plan, are they able to switch plans? What is the timeframe to switch? Is there an immediate change option for when a resident is auto enrolled in a plan and not accepted by provider? There use to be a way to change them within 24 hours for emergency change.	Medicaid members have 90 days to switch plans once they are enrolled into Medicaid managed care.
23		When someone is approved Medicaid, what does the enrollment into a Managed Medicaid look like? Is there a timeline?	Typically take up to 45 days from Medicaid application approval to enroll into the Medicaid managed care plan due to notice/member letter timelines.
24		Is there "Open enrollment" for Managed Medicaid plans moving forward every year?	Yes, yearly.