

# *Medicaid*

**Medicaid Matters New York**

# *Matters*

**Managed Care Workgroup**

## MEDICAID MANAGED CARE FACT SHEET

### **Know Your Rights: Continuing Your Ongoing Treatment While Transitioning from Medicaid into Medicaid with a Health Plan**

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Starting October 1, 2011, most Medicaid beneficiaries will be required to join a health plan to receive health care services. This is called Medicaid managed care. The questions and answers on this sheet will help you understand your rights during the transition process.

#### **WILL I LOSE ANY BENEFITS BECAUSE I JOIN A HEALTH PLAN?**

No. Medicaid managed care plans must cover everything that Medicaid fee-for-service covers. The difference is that you will now get most services through your health plan and you will have to follow the health plan's rules.

#### **WHEN SHOULD I START USING THE HEALTH PLAN?**

Once you enroll in a health plan, you will get a welcome letter with an effective date of enrollment. After that date you should start using the health plan providers and follow the health plan rules, like getting referrals from your primary care provider (PCP) to see the health plan specialists.

#### **DO I HAVE TO STOP AN ONGOING COURSE OF TREATMENT AND START ALL OVER AGAIN WITH THE HEALTH PLAN?**

You don't have to stop your Medicaid covered ongoing treatment when you enroll in a health plan. Your health plan must cover the treatment until it has an approved plan of care in place.

#### **WHAT IF MY DOCTOR IS NOT PART OF THE HEALTH PLAN (OUT-OF-NETWORK)?**

Your health plan has to cover your treatment for a transitional period when you have a life threatening, degenerative or disabling condition; and your treating provider is not in the health plan.

The transitional period lasts for:

- 60 days, or
- Until your health plan evaluates your needs and has an in-network plan of care in place for you

You should use the transition period to ask your doctor to join the health plan or to find a doctor in your health plan who can continue the treatment. During this time you should also work with your health plan to arrange your future care.

#### **HOW WILL I GET MY PRESCRIPTIONS ONCE I ENROLL IN A HEALTH PLAN?**

Starting October 1, 2011, you will no longer use your Medicaid card to get prescriptions. You will only be able to get your prescriptions through your health plan. Each health plan has its own list of drugs and rules on how

to get them. For this reason, it is important to check with your health plan to see if they cover your prescriptions, and what pharmacies you can use.

#### **WHAT IF MY HEALTH PLAN DOESN'T COVER MY PRESCRIPTIONS?**

During the first 90 days from your effective date of enrollment, you have the right to a one-time fill if you need a prescription that is not in the health plan's list of drugs or that has special rules. During this time:

- Ask your doctor if there is another drug you can take from the health plan's list of drugs, or
- Ask your health plan to cover the drug you need if you cannot take a different one.
- Call Community Health Advocates (CHA) for help getting the health plan to cover the prescriptions your doctor says you need. CHA's helpline number is 1-888-614-5400.

#### **CAN I CONTINUE RECEIVING HOME CARE?**

Once you enroll in a Medicaid health plan, you will receive all your home care services, including home attendant, housekeeping, home health aide and skilled nursing services, through your health plan unless you have Medicare.

Your health plan must cover any ongoing home care services you were receiving through Medicaid until it evaluates your needs and puts in place an approved plan of care.

#### **WHAT IF MY HOME CARE AGENCY IS NOT IN THE HEALTH PLAN?**

If your home care agency is not in the health plan, your health plan must cover your ongoing home care services for up to 60 days from the date of enrollment or until an in-network plan of care is put in place, whichever comes first.

#### **WHAT IF MY HEALTH PLAN TRIES TO STOP MY ONGOING TREATMENT?**

You can appeal any health plan decision you disagree with using the health plan's internal review process. You can also ask for a fair hearing at the same time. If you ask for a fair hearing within 10 days from the date the health plan informs you of their decision to stop services, you may be able to continue receiving treatment while you wait for your fair hearing decision.

#### **WHAT IF I CANNOT GET THE SERVICE I NEED FROM THE HEALTH PLAN?**

Ask the health plan to give you a case manager if you have problems getting the services you need. A case manager is a health plan employee who helps you coordinate your care. A case manager can help you get referrals, prior authorizations, etc.

If this still does not work, you can file a complaint with the plan. You can also call the Division of Managed Care of the State Department of Health to file a complaint. Their phone number is 1-800-206-8125.

File an appeal with the plan when the plan refuses to provide you with a service that you believe is medically necessary. You can also use the plan's appeal process and request a fair hearing. For advice on how to appeal or present your case at a fair hearing, contact your local advocacy organization, such as an Independent Living Center or legal services organization. You can also call the Community Health Advocates statewide hotline at 1-888-614-5400, which provides free information and assistance to New Yorkers seeking health care services and health insurance.