

YOU HAVE 90 DAYS TO JOIN A HEALTH PLAN

From now on, most people on Medicaid who are aged or disabled and are not on Medicare within your county must join a health plan. This means that you now must join a health plan to get most of your Medicaid benefits.

Some people with Medicaid are not required to join a health plan for special reasons. There are also people who can't enroll. A list is enclosed for you to look at or you can call your local Social Services office. You must tell us that you think you are exempt in 90 days, or you will be enrolled in the health plan.

You have the right to a fair hearing

If you request an exemption or exclusion, and do not get it, you may ask for a fair hearing. If you are told you must disenroll from managed care, you may ask for a fair hearing. For more information about fair hearings, call the Managed Care Office at your local department of social services.

What Happens Next

You will get a letter to confirm the date that you must begin using your health plan. Your new health plan will send you a welcome letter and a member ID card. If you need medical care before your health plan ID card arrives, use the health plan's welcome letter to show that you are a member.

After you join the health plan, you must use the hospitals, clinics, and doctors that work with the health plan. You won't be able to see your former doctor, or use the clinics and hospitals you do now unless they are in the health plan you choose.

Keep Both Your Medicaid Benefit Card and Your Health Plan ID Card. You will need to use your Medicaid benefit card to get pharmacy services and other services that may not be covered by your health plan, such as transportation, dental care and outpatient chemical dependence services. In addition, you will need your Medicaid benefit card to get mental health and some substance abuse services if you get SSI, Social Security Disability (SSD) or you are over 65, certified blind or disabled.

How Health Plans Work

You Have a Regular Doctor

When you join a health plan, you choose one doctor to be your regular health care provider. This person is your Primary Care Provider (PCP). Some plans will let you choose a nurse practitioner. Each of your family members will have a PCP who works with the health plan.

You can reach your PCP's office or health plan 24 hours a day, 7 days a week.

You Can Get Regular Check-ups

- Your PCP will give you regular check-ups to help prevent problems from starting or getting worse. Visit your PCP soon after you join a health plan.
- Your children will have regular check-ups as babies, young children, teenagers and young adults.
- You will get health care during pregnancy to keep you and your baby healthy.

You Can See Specialists

- Your PCP will give you a referral (permission) when you need to see a specialist.
- If you see a specialist often, you can ask your health plan to have your specialist be your PCP, or get special permission to see the specialist for a long period of time.

You Do Not Need a Referral for Some Specialists

You do not need a referral for your OB-GYN preventative services or for pregnancy care.

You do not need a referral to see another provider in your health plan for optical care OR one mental health assessment and one chemical dependence (including alcohol and substance abuse) service assessment in one year.

Your health plan must provide information in alternative formats if you need it, such as large print, recordings, or Braille. Your health plan must also provide interpreter services if you need those services when you contact the health plan. In some cases, health plans have the important written materials available in other languages.

Medicaid Benefits

When you join a health plan, you keep the same Medicaid benefits. Most Medicaid services are provided by the health plans. The only costs to you are the regular Medicaid co-payments you have now for pharmacy items. Among the services offered by the health plans are:

- Regular check-ups and shots
- Visits to the doctor when you are sick

- Care during pregnancy and family planning services
- Hospital care, lab tests, X-rays
- Referrals to specialists, when needed
- Emergency care
- Many other Medicaid services, such as eye care, medical equipment and HIV testing and counseling
- Transportation assistance (varies by county)
- FQHC Services (Federally Qualified Health Center services)

Using the Emergency Room

Go to the Emergency Room when you think there is a real emergency. Do not use it for routine care. Your Primary Care Provider (PCP) can treat problems that are not emergencies.

Some examples of medical emergencies are:

Passing Out	Trouble breathing	Broken bones
Convulsions (fits or spasms)	Miscarriage	Bad burns
Poisoning or drug overdose	Heart Attack	High fever
Bleeding that will not stop	A lot of pain	Rape
Any other serious problem	Head or eye injuries	Chest pains

If you go to the emergency room, call your health plan as soon as possible afterwards.

Family Planning Services.

Every member of every health plan can go to any Medicaid provider for family planning. You do not need a referral from your PCP for family planning. Here is a list of family planning services:

- Birth control pills, condoms, diaphragms, IUDs, Depo Provera, Norplant and foam
- Emergency contraception
- Pregnancy testing and counseling
- Sterilization
- Sexually transmitted disease testing and treatment
- HIV testing and counseling, when it is part of a family planning visit
- Abortions (that you and your doctor agree are necessary).

Problem Solving

If you have a problem call your health plan's Member Services Department. Each health plan has Member Services staff to:

- Tell you about the health plan and help you choose a PCP.
- Send you a member handbook and a member ID card with the health plan's phone number on it and the name of your PCP.
- Invite you to a meeting to learn about the health plan, or tell you about it over the phone.
- Answer other questions or solve problems that you have.

If You Have a Problem with Your Health Plan, You Can Do Any of the Following:

- Call the health plan's Member Services Department and tell them your problem. Often they can help. The number is on your health plan ID card.
- Ask for a fair hearing if your health plan has denied, stopped, or reduced covered services you think you should get. Call your LDSS Managed Care Unit to find out more about fair hearings.
- Call the State Department of Health Complaint Line, Monday through Friday, 8:30 a.m. to 4:30 p.m., at 1-800-206-8125, if you have a problem with your health services.

Know Your Rights In a Health Plan

You have the right to:

- Have all information about your health care kept confidential.
- Know how the health plan works, and what services it offers.
- Choose a PCP who will give you regular check-ups and keep track of all your health care.
- Get an appointment within 48 to 72 hours if you are sick and within 24 hours if you need care right away.
- If you do not need care right away, get an appointment for a check-up within 12 weeks of joining the health plan.
- Get a second opinion about certain medical conditions from another provider in your health plan.
- Change your PCP.
- Go to the Emergency Room for emergency care.
- Be treated with dignity and respect.
- Complain to the health plan, State Department of Health, or to your LDSS if you have problems with your health plan. You can reach the State Department of Health at 1-800-206-8125.
- Request a Fair Hearing. You can call 1-800-342-3334 to ask for a Fair Hearing.

Aged and Disabled People on SSI Who do NOT need to join a Health Plan

Some people with Medicaid do not have to join a health plan. They are exempt. This means that they can stay in regular Medicaid or they can join a plan if they wish. You have to tell the LDSS if you think you don't have to join. Here is the list of persons who are exempt and do not have to join:

- People with HIV Infection.
- People in long-term alcohol or drug residential programs.
- Pregnant women who are getting prenatal care from a provider who is not in any Medicaid health plan.
- People who live in facilities for the mentally retarded and people with similar needs.
- Some developmentally disabled people or physically disabled children who get care at home or in their community through the Care at Home or Community-Based waiver programs, or those who need the same kinds of care as people getting services through those programs.
- People with long-term health problems being treated by a specialist who is not in any Medicaid health plan.
- Native American persons.
- People who cannot find providers in any Medicaid health plan who can serve them in their language.
- People who live where they can't get to a Medicaid health plan.
- People temporarily living outside of the county.
- People scheduled for major surgery in the next 30 days, whose provider is not in a health plan.
- People with end-stage renal disease.
- People who are homeless, depending on the local social services district.
- Foster care children, depending on the local social services district.
- People eligible for Medicaid Buy-In (MBI) for working disabled – with income up to 150 % of the federal poverty level

Call your LDSS Managed Care Office for more information on exemptions. If you think that you are exempt (don't have to join), call your LDSS Managed Care Unit and ask for a Request for Exemption Form. Anything you say is confidential.

Some People MUST Stay With Regular Medicaid

Some people with Medicaid are not allowed to join a Medicaid health plan. This means they are excluded from joining a health plan and must stay with regular Medicaid. Here is the list of people who cannot join Medicaid managed care.

- People eligible for both Medicaid and Medicare (Medicaid Advantage).
- People in nursing homes, hospices, or long term health care and demonstration programs.
- Children or adults in state psychiatric or residential treatment facilities.
- People who live in Family Care Homes licensed by the Office of Mental Health.
- People who will get Medicaid for less than 6 months, except for pregnant women.
- People who are on Medicaid only after they spend some of their own money for medical needs (spenddown cases) or pay a Medicaid premium.
- People with other cost effective health insurance.
- Medicaid Buy-In for working disabled – with income between 150 % and 250 % of the federal poverty level.
- Babies under six months old who can get Supplemental Security Income (SSI), including low birth weight infants.
- Infants living with their mothers in jail or prison.
- People in the recipient restriction program.
- Blind or disabled children living apart from their parents for 30 days or more.

- People who are eligible for special Medicaid programs that only cover some medical services (You are not eligible for full Medicaid).
- Children in the care and custody of the Office of Children and Family Services.
- People who only get Medicaid through the Breast Cervical Cancer program.
- People who only get Medicaid through the Family Planning Benefit program.

If you become excluded from managed care after you join a health plan, you must disenroll from the health plan.

Call your LDSS Managed Care Unit if you think you are excluded from joining a health plan.

YOU HAVE THE RIGHT TO A FAIR HEARING

If you request an exemption or exclusion, and do not get it, you may ask for a fair hearing. If you are told you must disenroll from managed care, you may ask for a fair hearing. For more information about fair hearings, call your LDSS Managed Care Office.