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MEDICAID MANAGED CARE

100 MEDICAID MANAGED CARE PROGRAM

Certain Medicaid recipients are required to enroll with a Managed Care Organization (MCO) Plan, while other recipients have an option to enroll. A managed care organization is contracted with Nevada Medicaid and is responsible for providing full health care benefits including dental.

Clients with certain aid codes serviced in the Clark County and Washoe County areas are **required** to enroll with one of the MCO's listed below:

Health Plan of Nevada
Participant Services: 1-900-962-8074
Service Area: Clark and Washoe County

AMERIGROUP
Participant Services: 1-800-600-4441
AT&T Relay Service: 1-800-855-2880
AT&T Relay Service – Spanish: 1-800-855-2884

105 MANAGED CARE ORGANIZATION (MCO) ENROLLMENT

The Division of Health Care Financing and Policy (DHCFP) aka "Nevada Medicaid" is responsible for the enrollment of MCO Medicaid recipients. A Managed Care Enrollment Packet is sent to Medicaid recipients after approval of Medicaid benefits. Recipients have twenty (20) days to return the packet; DHCFP enrolls the recipient in one of the options if they fail to return the packet timely.

Family members must be enrolled in the same HMO. The choice belongs to the adult head of household or the authorized representative of a minor head of household.

The eligible aid codes for Managed Care are: AO, AO5, CH, CH5, AM, AM5, EM5, PM, PM5, PS, SN, SN5, TR, TR5.

Recipients are eligible for the Fee-for-Service Medicaid Plan for prior medical months and any months that lapse from the application date to the time of enrollment.

110 MEDICAID PARTICIPANTS EXEMPT FROM MANDATORY ENROLLMENT

Effective September 1, 1999, the Nevada Medicaid State Plan identifies the following Medicaid recipients as exempt from mandatory enrollment into a Medicaid managed care health plan:

- Recipients who are eligible for Medicare;
- American Indians who are a member of a federally recognized tribe [they may voluntarily choose to enroll];
- Children determined to have a serious emotional disturbance (SED) [they may voluntarily choose to enroll];
- Adults determined to have a serious mental illness (SMI) [they may voluntarily choose to enroll];
- Children under the age of 19 years old who are eligible for SSI under Title XVI:
- Children under the age of 19 years old who are eligible under Section 1902(e)(3);
- Children under the age of 19 years old who are in foster care or out of home placement;
- Children under the age of 19 years old who are receiving foster care or adoption assistance under Title IV-E;
- Children under the age of 19 years old who are receiving services through a family centered, community based, coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V; and is defined by the state in terms of either program participation or special health care needs (i.e., special children's clinic, first step or happy program) [they may voluntarily choose to enroll].

115 ENROLLING NEWBORNS

Newborns born to mothers receiving Medicaid who are enrolled with an MCO are added to the same MCO as their mother the month of birth. The Nevada State Division of Welfare and Supportive Services (DWSS) eligibility worker must approve Medicaid for the newborn immediately. The case manager cannot delay the Medicaid approval for the newborn because of necessary verifications they may be pending to add a newborn to a TANF or SNAP case.

120 CHANGING MANAGED CARE ORGANIZATIONS

The "Division of Health Care Financing and Policy (DHCFP)" instituted recipient lock-in requirement for managed care. The lock-in requires managed care recipients to remain enrolled in their Managed Care Organization (MCO) for 12 months unless they can prove good cause (as determined by DHCFP) for switching from one plan to another plan.

If a Medicaid recipient wishes to change from one HMO to the other or be removed from managed care, they should contact their current managed care plan directly.

135 GRIEVANCES

An informal oral or written grievance may be made to the Health Plan Provider or to an employee of the Nevada State Division of Welfare and Supportive Services (DWSS) by a recipient or a recipient's representative (including a provider on behalf of a recipient). If DWSS receives the complaint, they must forward it to the Managed Care program specialist at DHCFP.

The Health Plan Provider has ninety (90) days after a grievance is filed to resolve the problem with the enrollee and concerned parties.

Grievances are not eligible for referral to the State Fair Hearings process.

140 APPEALS

Participants have the right to appeal any decision made that denies, limits, reduces or suspends a service authorization request.

The Health Plan Provider has thirty (30) days to resolve the problem with the enrollee and concerned parties or refer enrollee to DHCFP for a state fair hearing.