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DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY
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1) **What is managed care and how does it work? What is a Managed Care Organization (MCO)?**
Managed care is a health care services delivery model. A managed care organization arranges for a medical service provider to provide health care services to individuals enrolled in their organization. Nevada Medicaid and Nevada Check Up contract with two managed care organizations to provide Medicaid services to most of our recipients who live in urban Washoe or urban Clark County.

One of the two MCOs is Health Plan of Nevada, also known as HPN, Smart Choice, Northern Choice or Nevada Check Up. The other MCO is AMERIGROUP, which is owned by Anthem BCBS and also goes by the names AMERIGROUP Community Care and AMERIGROUP Real Solutions.

2) **Why can't I go to my regular doctor?**
Your Managed Care Organization (MCO) contracts with some doctors but not all doctors, and you must use a doctor that is in your MCO's network. Your MCO carefully credentials the doctors in their medical provider network so you can be assured that you will be able to access health care. If you are in the middle of a treatment when your enrollment into your chosen or assigned MCO begins, notify your MCO, your MCO must let you continue that treatment until they can transition you to another doctor.

3) **Why am I in managed care? Why can I not have Medicaid Fee for Service (FFS)?**
If you are on Medicaid and you live in urban Washoe County or Clark County, managed care enrollment is mandatory unless you are under the special Medicaid category of aged, blind or disabled. Your eligibility category is determined by the Division of Welfare and Supportive Services (DWSS) as part of your Medicaid application process.

At the time that you apply for Medicaid, you are requested to choose the Managed Care Organization (MCO) that you prefer, Health Plan of Nevada (HPN) or Amerigroup. That choice is checked against our enrollment rules to determine if your choice can be honored (see Question 5). If you do not choose a plan, you will be automatically assigned to a plan.

The following recipients are enrolled into managed care but, by federal regulation, may request to be disenrolled from managed care.

1. American Indians/Alaskan Natives can do this through their Tribal Clinics.
2. Children determined Severely Emotionally Disturbed (SED) and some adults determined Seriously Mentally Ill (SMI). The determination must be done through your MCOs behavioral health providers. ***Restrictions apply.***

3. Children with Special Health Care Needs: "Children under the age of 19 years 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 (also known as Children with Special Health Care Needs – CSHCN)". Opting out is done through Nevada Early Intervention Services

4) Why are some of my family members in Fee for Service (FFS) and some in managed care?

A case can have family members who have been approved by the Division of Welfare and Supportive Services (DWSS) with different eligibility categories. Some eligibility categories are exempt from managed care. Some family members may qualify as a voluntary population (see Question 3). Whether or not *you* are required to be in managed care is based on where you live and what eligibility category *you* have been approved for by the DWSS. If you are questioning your eligibility category, you must contact your local DWSS office.

All family members who are required to be in managed care must be enrolled in the same Managed Care Organization (MCO).

5) Am I allowed to choose which Managed Care Organization (MCO) I want?

At the time that you apply for Medicaid, you are asked to choose the Managed Care Organization (MCO) that you prefer, Health Plan of Nevada (HPN) or Amerigroup. That choice is checked against our enrollment rules to determine if your choice can be honored.

There are a number of factors in our enrollment rules. Situations such as is anyone else on your case already enrolled in a MCO; whether or not you have recent enrollment history in a MCO: these are reasons that you may be placed in a MCO that you did not choose.

- All family members on a case who are required to be in managed care must be enrolled in the same MCO. A new family member joining a Medicaid case will be enrolled into the MCO that existing case members are currently enrolled in.

- If you have recently lost your Medicaid eligibility and your eligibility is being reinstated, you may be placed directly back into your history MCO.

Once a year during open enrollment you will be able to change your managed care organization.

6) What is Open Enrollment? When is it?

Once a year the State holds an Open Enrollment period to allow all Medicaid recipients enrolled in managed care the option to switch from their current Managed Care Organization (MCO) to the other plan.

Every year, at the beginning of July, the State will mail Open Enrollment letters to all Medicaid managed care households. Both MCOs will also mail marketing materials to the same households, highlighting their services and benefits. If the family members

decide they wish to switch their MCO, they must follow the instructions on the letter; the bottom of the letter is a slip that should be filled out, signed and mailed back to Hewlett Packard Enterprise Services (HPES) by the deadline listed on the letter (mid September). The mailing address is:

HPES
PO Box 30042
Reno, NV 89520

All Open Enrollment switch requests will be effective October 1st. Once Open Enrollment is over, the family is once again considered locked in to their MCO until the next Open Enrollment period.

7) **What does it mean that I am 'locked-in' to my Managed Care Organization (MCO)?**

Only on two occasions are you allowed to choose/change your Managed Care Organization (MCO). 1) When you are new to Medicaid; at the time that you apply for Medicaid, you are requested to choose the Managed Care Organization (MCO) that you prefer, Health Plan of Nevada (HPN) or Amerigroup. In your initial 90 days of managed care enrollment you are allowed to switch your MCO. 2) During each annual Open Enrollment period.

Outside of these two times, you are considered 'locked-in' to your MCO. This means that you are not allowed to switch your MCO without good cause and must wait until the next open enrollment period. During this time, you may ask your MCO to approve a Good Cause switch to the other health plan. It is at the discretion of your MCO to approve or deny your request.

8) **How do I change my Managed Care Organization (MCO) if I am not happy with it? When will the change be effective?**

Depending on whether you are 'locked-in' to your current Managed Care Organization (MCO) (see Question 7) there are steps you can take to switch from the MCO you are enrolled in into the other MCO. This process is to switch from one MCO to the other, not to switch from managed care to Fee for Services (FFS).

If you are not locked-in to your MCO, follow the below steps to submit your request to switch your MCO:

Submit a written request that includes a brief statement of your request, your Medicaid Id, your signature and the date. Mail this letter to Hewlett Packard Enterprise Services (HPES) at:

HPES
PO Box 30042
Reno, NV 89520

It is suggested that you keep a copy of the correspondence that you mail.

If your request for an MCO switch is approved, your switch will become effective the first of the next possible month. This means that if HPES receives and processes your

request early enough in the month, your request will be effective the next month. If your request is received and processed by HPES late in the month, your request will not be effective for another month.

9) **I was enrolled in a different Managed Care Organization (MCO) than I chose on my application. What do I do?**
At the time that you apply for Medicaid, you are requested to choose the Managed Care Organization (MCO) that you prefer, Health Plan of Nevada (HPN) or Amerigroup. That choice is checked against our enrollment rules to determine if your choice can be honored.

Refer to Question 5 for reasons why your choice may not be honored.

If you did not join an existing case and have not had recent Medicaid eligibility, the choice may have been entered incorrectly in the enrollment process. If you believe a mistake has been made please contact your local Medicaid District Office to have your case reviewed.

10) **Can my enrollment with my Managed Care Organization (MCO) be retroactive?**
Enrollment into managed care is not retroactive, even if you have been approved for prior medical coverage through the Division of Welfare and Supportive Services (DWSS).

11) **I have moved out of Washoe or Clark County. How do I disenroll from managed care so that I may access services?**
Most importantly, you ***must*** report any changes to the Division of Welfare and Supportive Services (DWSS), including address changes, within 10 days.

To report an address change to DWSS, use the below contact information:

For Northern Nevada call 775-684-7200
For Southern Nevada call 702-486-1646

Option 1 for English, 2 for Spanish
Option 1 for TANF/SNAP/Medicaid
Option 2 for Existing Case
Option 4 for Report Change

In the event that you have moved from Washoe or Clark County to a Fee for Service (FFS) area, and DWSS has processed your address change, your Medicaid case will automatically be disenrolled from managed care effective the first of the next possible month. This means that if DWSS updates your case information early enough in the month, your disenrollment will be effective the next month. If your case update is processed by DWSS later in the month, your disenrollment will not be effective for another month.

Until your address change has been processed by DWSS and while you are waiting to be disenrolled from managed care, your Managed Care Organization (MCO) has policies in place to ensure you have access to your Medicaid benefits; they can assist

you if you need to see a physician or fill a prescription. Contact your MCO for assistance.

12) What benefits do I receive through my Managed Care Organization (MCO)?

With managed care you receive all the same benefits that someone in Fee for Services (FFS) receives. Plus, each Managed Care Organization (MCO) offers added benefits to their members, above and beyond what FFS provides. For a complete list of benefits, please contact your MCO. Some services require a prior authorization.

13) What is a 'prior authorization' (PAR)?

Prior authorization is a requirement that your physician obtain approval from your Managed Care Organization (MCO) to provide a specific service, perform a specific procedure or prescribe a specific medication for you. Without this prior approval, your MCO may not provide coverage or pay for your service, procedure or medication. Your physician, in the event that prior authorization is required, will work with your MCO to obtain the authorization.

14) Why do I have an additional medical card besides my Medicaid Card?

Amerigroup sends a benefits card to Medicaid members enrolled in their plan. Health Plan of Nevada (HPN) does not. Everyone on Medicaid receives a benefits card from the Division of Welfare and Supportive Services (DWSS). If you are enrolled with Amerigroup, you can use their card while accessing services. If you are enrolled in HPN, you should use your Medicaid card issued by DWSS. *The Medicaid card issued by DWSS is your primary benefits card no matter what Managed Care Organization (MCO) you are enrolled with and should never be disposed of.*

15) Who should I contact if I have not received my Medicaid Card?

Medicaid cards are issued by the Division of Welfare and Supportive Services (DWSS). If you are in need of a new card please call DWSS for assistance.

For Northern Nevada call 775-684-7200
For Southern Nevada call 702-486-1646

Option 1 for English, 2 for Spanish
Option 1 for TANF/SNAP/Medicaid
Option 2 for Existing Case
Option 4 for Report Change
Option 5 to speak to an agent

16) How do I know which providers are in my Managed Care Organization (MCO) network?

Each Managed Care Organization (MCO) has up-to-date network lists available on their websites, or you may call the MCO directly and ask for a provider list to be mailed to you.

You may also ask your provider's office or pharmacy which MCO(s) they are contracted with.

17) **My Managed Care Organization (MCO) is Health Plan of Nevada (HPN). How do I contact them?**
Member Services: (702) 242-7317 or (800) 962-8074
http://www.hpnmedicaidnvcheckup.com

18) **My Managed Care Organization (MCO) is Amerigroup (AGP). How do I contact them?**
Member Services: (800) 600-4441
www.myamerigroup.com/NV

19) **What do I do if a service or prescription has been denied by my Managed Care Organization (MCO)?**
Please contact your Managed Care Organization (MCO) regarding your denial. You do have appeal rights.

20) **I have a complaint against my Managed Care Organization (MCO), where or who can I send my complaint to?**
Please contact your Managed Care Organization (MCO) for instructions on how to file a grievance or complaint.

21) **I have Nevada Check Up. Do I qualify for managed care?**
If you are on Nevada Check Up and you live in Washoe County or Clark County, managed care enrollment is **mandatory**.

22) **Does Amerigroup and Health Plan of Nevada (HPN) offer transportation for my medical appointments? Who do I speak to?**
The health plans do not provide transportation. Nevada Medicaid provides eligible Medicaid recipients with transportation to covered services that are medically necessary. Nevada Check Up recipients are not covered for non-emergency transportation services. The transportation broker under contract with Nevada Medicaid is LogistiCare.

Non-emergency transportation always requires prior authorization by LogistiCare. Medicaid recipient participants must call LogistiCare to request rides to a covered medically necessary service and/or to request mileage reimbursement if a personal vehicle is used.

LogistiCare may be reached 24 hours a day, seven days a week at
1-888-737-0833
http://www.logisticare.com