



Medical Home Workshop

The Medical Home:

- What is it?
- Why should my child have a primary care provider?
- Can I get insurance coverage?



Where Do I Go???

- My three year old son was up coughing all night.
- My thirteen year old daughter seems very sad.
- I wonder if my two year old is deaf.



The Medical Home* is...

- not a place or building!
- but... an approach to providing high-quality, cost effective health services;
- a coordinated & respectful health care partnership among a child, his/her parents and the child's Primary Care Provider

* Initiative funded by MCH Bureau & HRSA



Qualities of a Medical Home...

- Accessible
- Family-centered
- Continuous
- Comprehensive
- Coordinated
- Compassionate
- Culturally Effective



Primary Care Providers are the Key to your Child's Medical Home ...

- Pediatrician
- Family Doctor
- Local Health Centers



Why Does My Child Need a Primary Care Provider?

- Access to a medical home
- Early and continuous screening/prevention
- Community based systems of care that are culturally competent
- Access to affordable health insurance
- Family & youth participation & satisfaction
- Services necessary for transition to adulthood



Benefits of having a Primary Care Provider

- Ideal source: knowledgeable & willing PCP, capable of working with you to identify and access all the (medical and non-medical) services needed for your child and family to reach your maximum potential
- Whatever her practice setting, the provider must work to provide services that meet American Academy of Pediatrics criteria for a Medical Home

Expect your PCP to...



- See to your child's basic health needs
- Coordinate medical care, including routine, preventive, urgent, & specialty
- Make referrals (& standing referrals)
- Take care of prior authorizations
- Help with appeals or fair hearings



What About Insurance Coverage?

- Managed Care
- Medicaid Managed Care
- New Jersey Family Care



MANAGED CARE

- a comprehensive approach to providing and paying for high-quality **medically-necessary** health care services -
- from routine to emergency -
- within a coordinated system -
- in a cost-effective manner



What managed care covers

- plans differ in services covered
- member handbooks list **covered services**
- services are covered only if **medically necessary** for your specific health needs
- emergency room care is covered only for a **true emergency**
- Specialty services usually require a **referral** from your Primary Care Provider

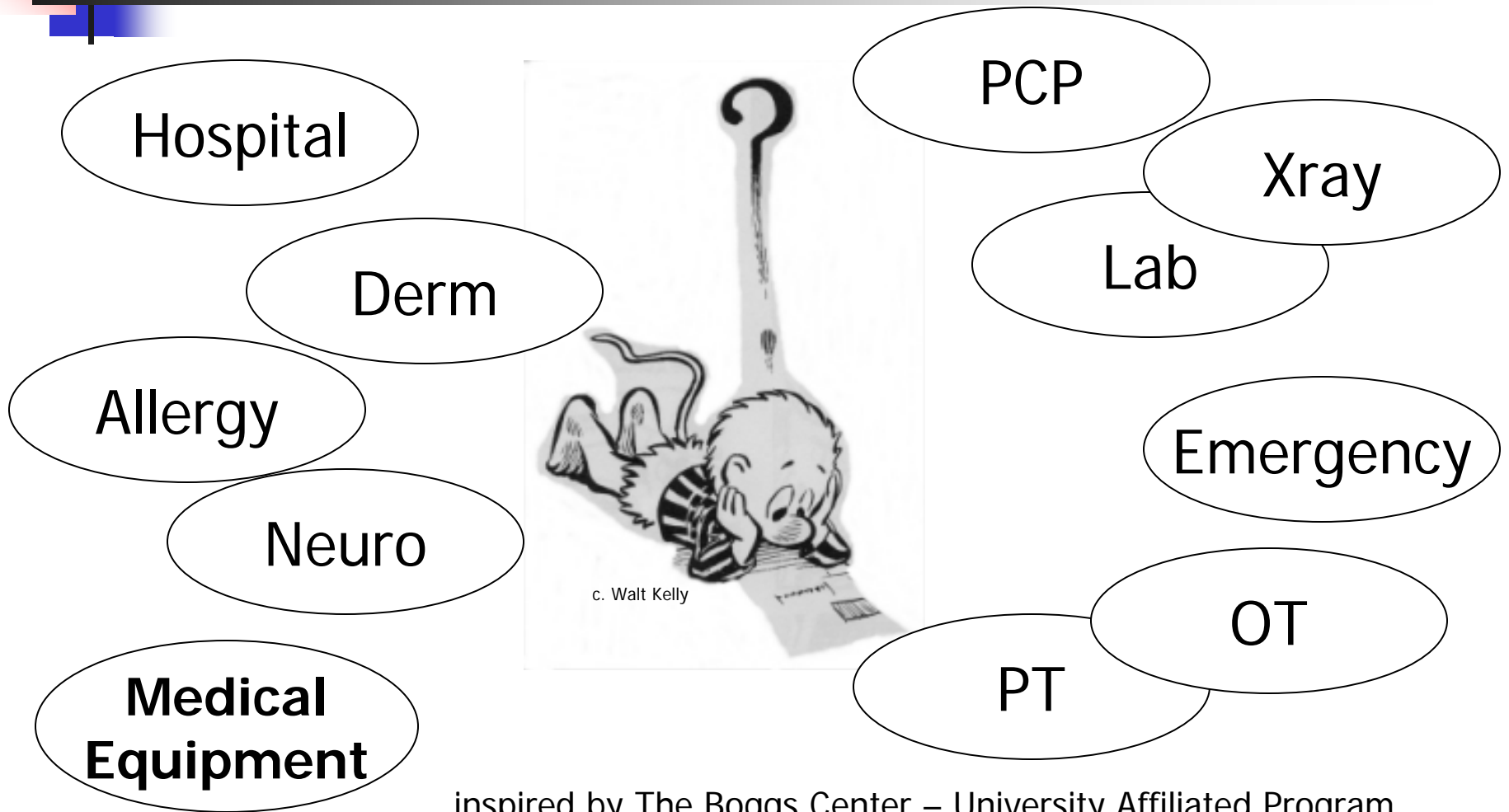


“Hallmarks” of Managed Care

- Using specific “network” providers
- Not relying on the emergency room for primary care services
- Authorizing of specialty care and referrals

...from the Boggs Center, University Affiliated Program

Benefits of Managed Care



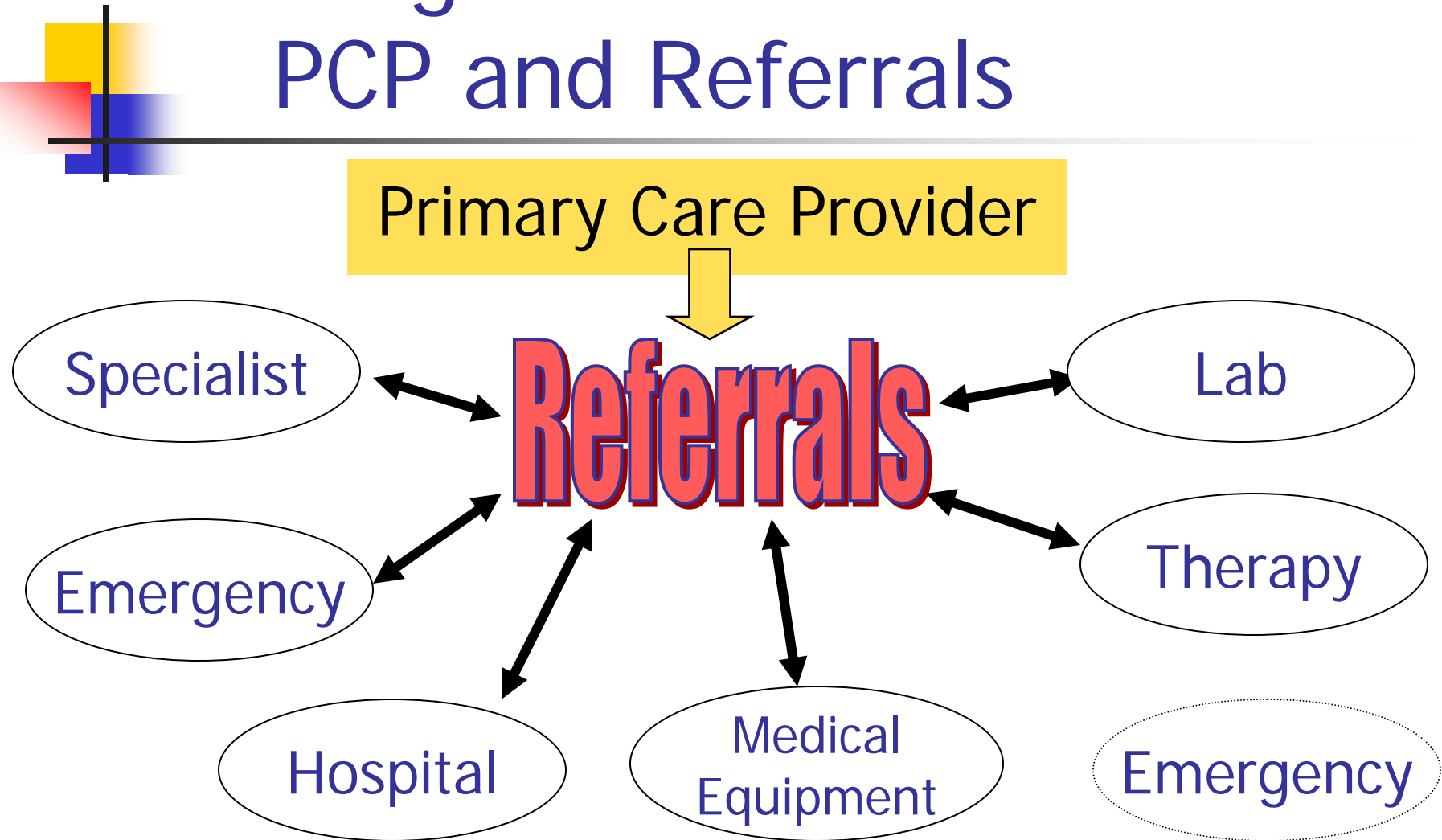
...inspired by The Boggs Center – University Affiliated Program
Medical Insurance - 1



Managed Care & The Primary Care Provider

- A physician or other professional you choose from your managed care plan network who is responsible collaborating with you to manage all your child's health care needs
- the managed care model works well with the Medical Home concept

Managed Care: PCP and Referrals



... from the Boggs Center – University Affiliated Program



Medically Necessary Services are services required to:

- diagnose or prevent an illness, injury or condition
- treat an illness, injury, or condition
- keep condition from getting worse
- lessen pain or severity of condition
- help improve condition
- restore lost skills (rehabilitation)



Medically Necessary Services...

- are consistent with diagnosis;
- meet accepted standards of good medical practice;
- can be safely provided.
- *HMO clinicians may review a PCP's proposed course of treatment to determine medical necessity*



Medically Necessary: requirements for children

- The service is appropriate for the age & health status of the child;
- the service will aid overall physical & mental growth & development; and/or
- the service will assist in achieving or maintaining functional capacity.

MEDICAID MANAGED CARE

(New Jersey Cares 2000+) Who must enroll?

- New Jersey Care 2000:
Mandatory since 1995 for people receiving WFNJ/TANF benefits.
- New Jersey Care 2000+ :
ABD (“aged, blind, or disabled”) Population:
(people with disabilities who receive Supplemental Security Income and Medicaid).
About 90,000.
(enrollment frozen in most NJ counties, tho’ Medicaid recipients **may enroll** in any part of the state):



Exemptions to Medicaid Managed Care Enrollment

- People who are eligible for both **Medicaid and Medicare** do not have to enroll in Medicaid managed care at this time (although they may elect to do so if they wish).
- Families of children with **complex medical or mental health needs** may be allowed to continue with their fee-for-service providers and not enroll in an HMO. Apply thru HBC.
 - Denials of exemption requests may be appealed through the **Medicaid Fair Hearing** process.



Exemptions – continued

- Consumers already enrolled in a private HMO that does not have a contract with the state

(this exemption does not apply to consumers with private fee-for-service insurance or enrolled in preferred provider organizations).



Medicaid Beneficiaries excluded from Medicaid managed care:

- Those living in institutions
- Those in some home and community-based waiver programs
- Those in out-of-state placements



Medicaid Managed Care Providers

- The following HMOs provide the Benefits Package for the Medicaid managed care system in New Jersey:
 - Americhoice (not in Trenton)
 - Amerigroup New Jersey (not in Trenton)
 - Horizon/Mercy
 - Health Net (not in Trenton)
 - University Health Plans
- HMOs provide coverage for enrollees in a geographical area for a prepaid, fixed premium (capitation)
- HMOs provide larger menu of services than traditional fee-for-service Medicaid



“Hallmarks” of Managed Care

- Using specific “network” providers
- Not relying on the emergency room for primary care services
- Authorizing of specialty care and referrals

...from the Boggs Center, University Affiliated Program

How is Medicaid Managed Care different from traditional Medicaid?



- **Health Benefits Coordinator (HBC) non-HMO**
- **HMO ID card**
- **HMO Member handbook**
- **HMO Primary Care Provider (PCP)**
- **HMO Care Manager**
- **HMO Individual Health Care Plan (IHCP)**
- **HMO Provider Network (provider directory)**
- **Referral**
- **Prior authorization**
- **Emergency vs. urgent vs. routine care**
- **HMO Benefits Package**



What's the same?

- Medicaid eligibility letters (keep with your HMO ID card)
- “excluded” or “carve-out” services: those services provided outside the HMO which are paid for on the traditional Medicaid **fee-for-service** basis (coordinate these with your HMO care manager and be sure they are included in the Individual Health Care Plan)



Covered Services

- **HMO benefits package**
 - **See Fact Sheet 1, page 4**
 - **These services are provided for by the HMO**
 - **Include mental health & substance abuse services for DDD clients**
 - **Include some transportation**
 - **HMOs may offer participants additional services beyond those Medicaid entitles them to**
- **HMO excluded services, or “carve out” services***
 - **PT, OT, Speech**
 - **Some transportation**
 - **Mental health & substance abuse for non-DDD clients**
 - **Some meds**
 - **Some blood products**
- ***Are still paid for by Medicaid fee-for-service**



Medicaid generic drug policy

- Use of generic drugs is mandated for Medicaid recipients (with exemptions)
- Substitutions for generic drugs require prior authorization. Ask your PCP to handle this
- Prescribing MD should write on Rx: “brand medically necessary - do not substitute”
- Pharmacist may dispense \leq 10 days brand name drug while awaiting prior authorization



Costs

- **Medicaid entitles beneficiaries to free health care.**
- **Enrollees who follow correct HMO procedures should never receive a bill.**

(If they don't follow procedures they may be held liable for bills.)



Using Medicaid Managed Care

- Call the HBC to enroll in an HMO
- Read your HMO member handbook
- Select and work with your PCP
- Get referrals for other services
- Work with your care manager
- Use network providers
- Use emergency rooms only for emergencies (prudent layperson decision)
- (Apply for Medicaid Managed Care exemption?)



Choosing ... plans

- Which Medicaid HMO is best for your child?
 - Which HMO provider network(s) are your child's most important current providers in?
 - Ask your providers or the HBC.
 - Some of your providers may be able to join the provider network for the HMO that looks best to you. Ask the HMO's member services.
 - Which HMO best meets most of your requirements?
 - See Fact Sheet 2, page 3 for questions to ask. Compare the HMO member handbooks or see brochures available from HBC or ARC of New Jersey; or call the HMOs and ask to talk to a care manager about services and providers.
- Choose the plan that includes your current providers or that meets most of your requirements



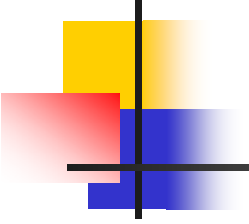
Choosing your Primary Care Provider

- Who is the best PCP for your child?
 - Does the provider have experience working with families of children with special health care needs?
 - Has he worked with children with your child's special needs before?
 - Who will see you when she's not available?
 - Is his office close to your home?
 - Are the office & exam rooms accessible to you?
 - Does this provider speak your language or sign?
- Ask to speak to a care manager at the HMO about these questions.



Once you've chosen...

- Read your Member Handbook carefully!
- Identify important people and phone #s and post them by your phone
- **Be sure you learn how to reach help after hours!**
- Keep records of all provider contacts in case misunderstandings arise



After you've chosen, you may still change...

- ...HMOs if you have major problems.
 - Call the HBC to process changes
 - Changes take time – 45 days or more
- ...PCPs if you are not satisfied with your first selection.
 - Call HMO member services, or talk to your care manager for information.



Expect your care manager to...

- Have experience with people with special needs
- Probably be one of your best troubleshooting resources
- Coordinate all your child's services & needs
- Develop an **IHCP** with you and your child
- Help with referrals & locating specialists

You should call your care manager to get a basic care plan started soon after HMO enrollment.



If you have a problem with...

- A provider, talk to your care manager or PCP
- Your care manager or your PCP, call your HMO's member services
- With your HMO not meeting your child's needs, call
 - Medicaid Managed Care Hotline 800-356-1561
 - or Managed Care Consumer Assistance Program (MHCCAP) 888-838-3180



Medicaid Fair Hearing

- Within 90 days of service denial, you can file for a fair hearing
- Call the Medicaid Hotline at the NJ Department of Human Services 800-356-1561
- At a fair hearing, an impartial judge listens to your position. You can bring witnesses and cross-examine the HMO's witnesses
- It's a good idea to take legal representation to the fair hearing. Call Community Health Law Project or Legal Services of New Jersey.



Top Resources for questions about Medicaid Managed Care

- Your HMO care manager
- Medicaid managed care hotline
1-800-356-1561
- Managed Health Care Consumer Helpline
1-888-838-3180
- The Health Benefits Coordinator (HBC)
1-800-701-0720



Resources for Support and Information about Medicaid Managed Care

- Family Voices Resource List: important literature and phone numbers to help you with Medicaid managed care questions.
- Family Voices Fact Sheets or web page at http://www.spannj.org/familywrap/medicaid_fact_sheets.htm



EPSDT

Early & Periodic Screening, Diagnosis, & Treatment

- Medicaid's comprehensive & preventive health program for children under 21
- Provides screening & services at medically-appropriate intervals
- Provides medically necessary health care services



States must inform

all Medicaid-eligible
persons under 21 that
EPSDT is available



EPSDT Screening

- Health and developmental history, including mental health
- Comprehensive physical exam
- Appropriate immunizations
- Laboratory tests
- Health education



EPSDT additional screening (minimal requirements)

- Vision: diagnosis/treatment for vision defects, including eyeglasses
- Dental: maintenance of dental health, relief of pain/infections, restoration of teeth
- Hearing: diagnosis/treatment for defects in hearing, including hearing aids



EPSDT -

- **Diagnosis:** if screening indicates need for further evaluation, referral and follow-up
- **Treatment:** health care must be made available to treat/correct/ameliorate physical, developmental, or mental health conditions discovered during screening



EPSDT - lead poisoning prevention

- Required component of screening
- All children at 12 and 24 months
- Children over 24 months if no record of previous test
- Medically-necessary diagnostic and treatment services must be provided to child with elevated blood lead level



Welfare, Supplemental Security Income, and Medicaid

- if your family **loses** eligibility for **welfare** (Work First New Jersey Temporary Assistance for Needy Families) due to time limits or income changes, or
- if your child **loses** eligibility for **SSI** due to health improvement or income changes
- **Your child may still be eligible for Medicaid!!!**



for more info
about Welfare, SSI & Medicaid

- Consult the Medicaid Hotline at
1-800-356-1561
- Or your local county welfare agency
(see the blue pages of the phone book)



NJ FAMILY CARE

- A Federal- & state-funded health insurance program which helps uninsured children receive free or low cost health coverage
- Available based on family size & monthly income (not assets)



NJ Family Care is...

- health insurance for New Jersey's uninsured children
- not a welfare program
- for working families who cannot afford to buy health insurance privately



NJ Family Care Costs...

- varying plans with different costs
- premiums and copays are based on family income; for some families there are none
- (families should contact their County Board of Social Services office in case they're eligible for other services besides NJ Family Care)



NJ Family Care Eligibility...

- Children 18 & under
- Legal permanent residents of state or other qualified immigrant status (regardless of date of entry)
- Only children who have been uninsured for 6 months or longer (with some exceptions)



NJ Family Care Covered Services...

- Doctor visits
- Immunizations
- Eyeglasses
- X-rays, laboratory & other diagnostic tests
- Prescriptions
- Hospitalizations
- Mental health services
- Dental care for most children

Questions? Want to apply?

Call **1-800-701-0710**



CASE MANAGEMENT SERVICES

- In each NJ county, case management units work with families to
 - promote family-centered, community based care
 - coordinate service deliveryfor your child with special health care needs.



How does Case Management work?

- A nurse or social worker coordinates with your family and your child's physician to
 - compile your child's medical records into one file
 - develop a unified plan of care to address your child's/family's needs
 - identify resources you need so your child receives appropriate care.



How can I find out more about case management?

- For information about county-based Case Management Services, contact the NJ Special Child Health Services Program, New Jersey Department of Health and Senior Services

at

609-777-7778