



Health Care for Children with Special Health Care Needs

Helping NJ Families access health coverage
and health services for their children

Family-to-Family Health Information & Resource Center

A Project of Family Voices-NJ @ the
Statewide Parent Advocacy Network



Advocacy for Children & Youth with Special Health Care Needs

Health Insurance Models (Managed Care, including Medicaid, Early Periodic Screening, Diagnosis and Treatment, and Family Care; Fee for Service; Federally Qualified Health Centers; and Charity Care) – What are they and Who is Eligible? How to apply? Appeal denials of eligibility?

Session I: April 11, 2007

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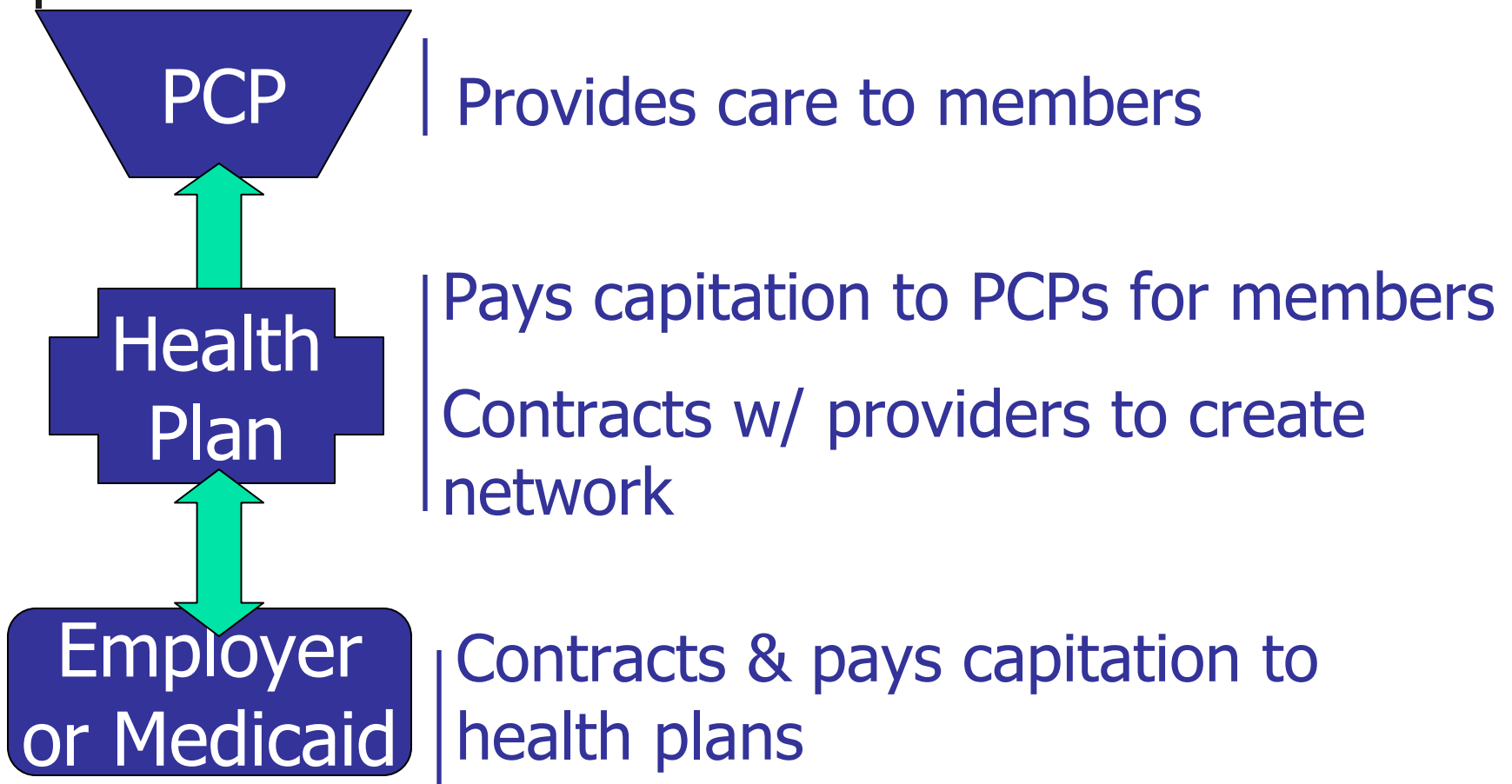


HEALTH INSURANCE - FFS

- **Indemnity or Fee-For-Service**
 - Use any doctor without referral
 - Deductible to meet, then % of cost covered (usually 80/20 split)
 - May require prior approval for hospitalization/outpatient procedures
 - Consumer files claim forms
 - No preventive coverage

Payment for Health Services:

Capitation = fixed \$ amount per member





HEALTH INSURANCE - HMO

- **Health Maintenance Organization**
 - Use any network hospitals and physicians
 - Preventive care covered
 - referrals or prior authorization via “gatekeeper” for all other health services
 - Small copay
 - No paperwork
 - Several models



HEALTH INSURANCE - POS

- **Point of Service**

- Use any provider
- Lowest copay network providers;
higher copay from listed providers;
highest copay out of network
- In network, “gatekeeper” referrals for all services
- Preventive care usually covered

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HEALTH INSURANCE - PPO

- **Preferred Provider Organization**
 - Use any doctor or hospital, lower copay in-network
 - No referrals needed to network providers
 - Some preventive services may be covered
 - Prior approval for hospitalization & some outpatient procedures



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



Health Maintenance Organizations (HMOs)

- Most of the health plans that provide and pay for managed care health services.
- HMOs provide coverage for enrollees for a prepaid, fixed premium (capitation).
- HMOs may provide a larger menu of services than traditional fee-for-service plans (for example, preventive)



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

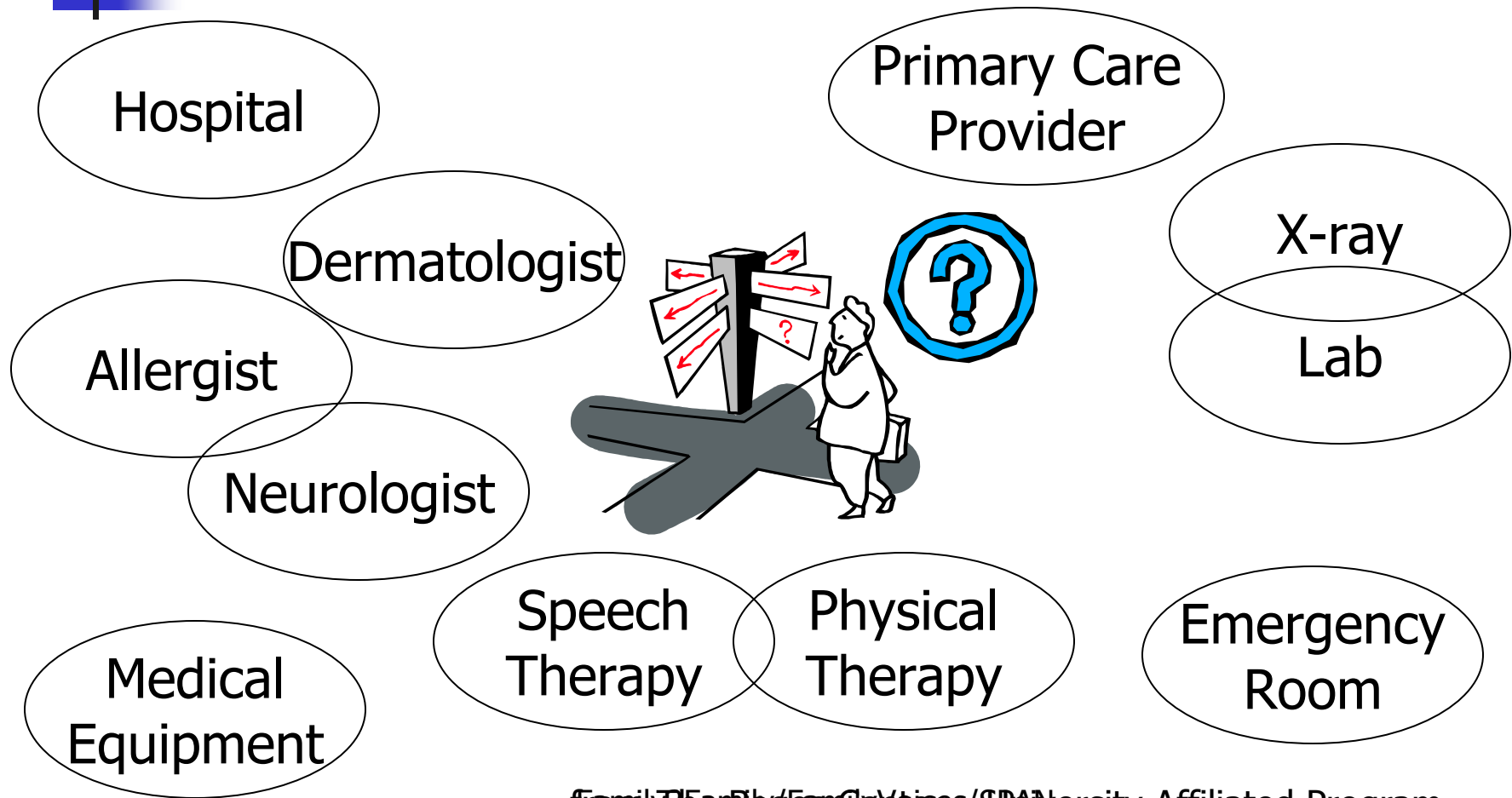


“Hallmarks” of Managed Care

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

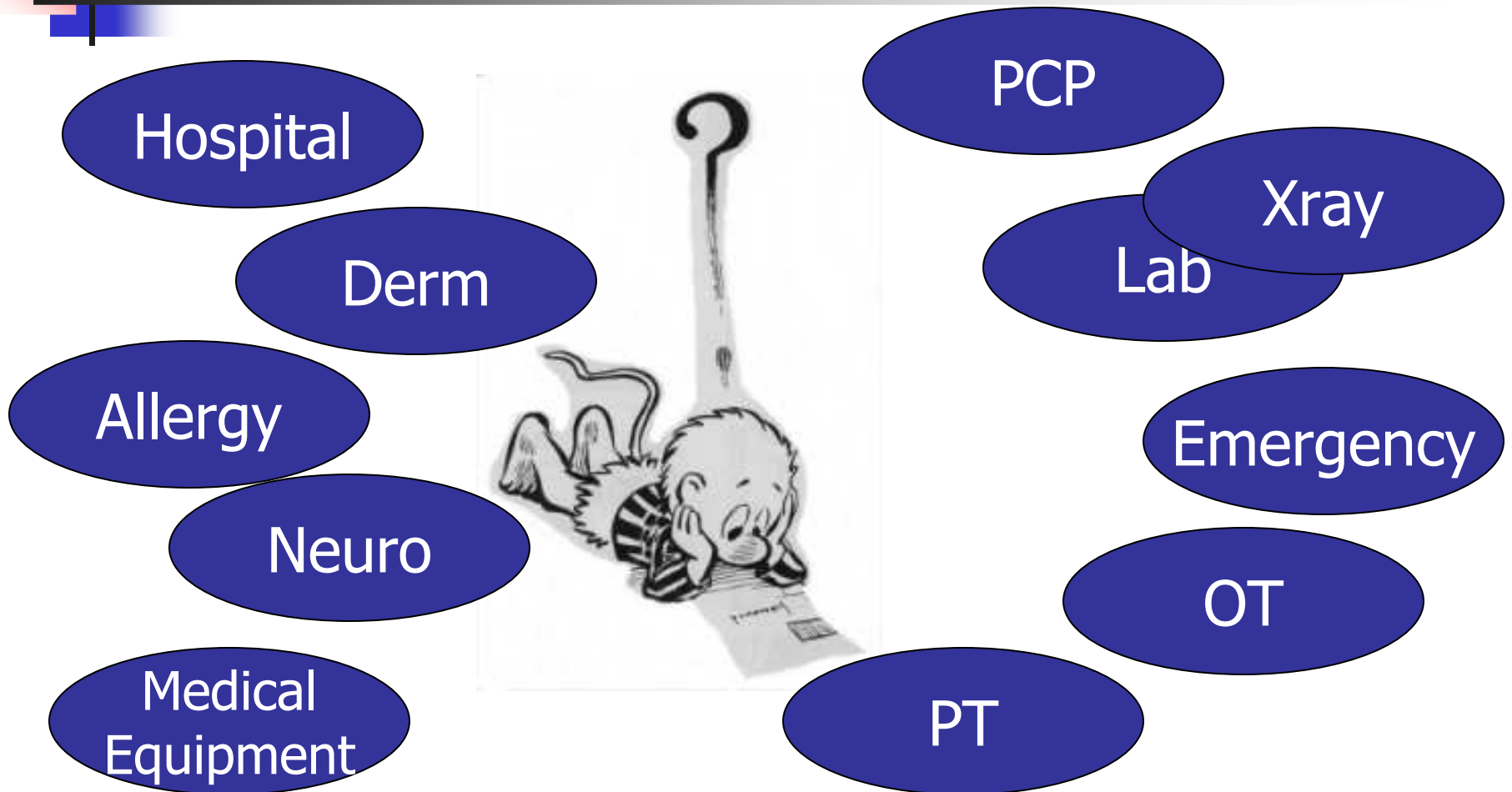
...from the Boggs Center, University Affiliated Program

Fee for Service: Unmanaged Care

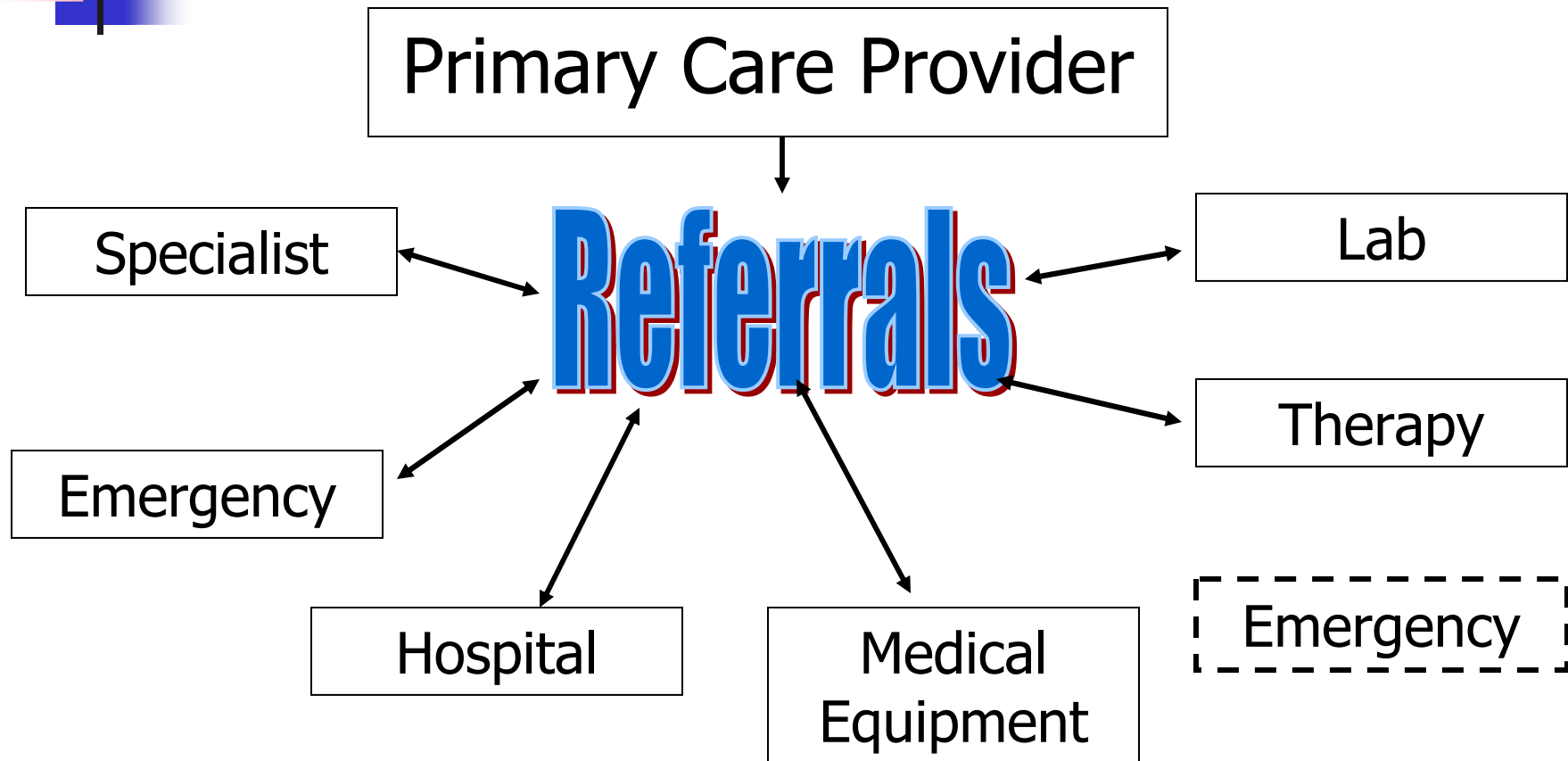


Fee-for-Service: Unmanaged Care

...what managed care intends to address



Managed Care: PCP and Referrals



... from the Boggs Center - University Affiliated Program
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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 **grievances** or **appeals**
- **You should keep your PCP informed of other provider visits, including emergency room visits.**



Pharmacy Services

- Read your member handbook to understand how and where to get your child's meds
- Fill your prescriptions only at a participating provider pharmacy
- HMOs use **Formularies** of preferred medications
- **Medically-necessary** medications are covered, though copays are not unusual.
- Your copay may be larger for a brand-name prescription than for a generic prescription.



Important Facts About Medicaid

- Medicaid provides health insurance for 3 in every 10 American children
- Largest children's health program
- Primary source of healthcare for low-income families, elderly & disabled
- Over 1/2 of Medicaid enrollees are children
- Most children receiving Medicaid (75) live in families with at least one working parent



Important Facts About Medicaid

- Medicaid is a joint program with costs shared by federal & state government
- Medicaid serves over 24 million children
- Each state establishes its own standards for Medicaid eligibility, benefits package, & provider payment rates, within federal guidelines that set certain minimum standards and benefits



Important Facts About Medicaid

- Children covered by Medicaid must have access to the same care & services as children with private insurance
- Over 2/3 of pediatricians accept Medicaid; 1/3 of pediatricians help enroll additional eligible children
- The federal government reimburses NJ for at least 50% of Medicaid expenditures



Why is Medicaid important?

- Critical health care safety net for millions of low-income children
- Covers all services that doctor or health professional identifies as “medically necessary” including:
 - Physician & hospital visits
 - Well-child visits & health care
 - Health screenings
 - Vision care & dental services



Medicaid in New Jersey

- 22% of NJ's children are enrolled in Medicaid
- 1 in 9 NJ children is uninsured (226,990 children)
- The cost to NJ of each Medicaid-eligible child is just \$1,936 on average
- NJ will lose \$10 in federal funding for every \$10 it cuts from State Medicaid



Sources of Medicaid in NJ

- Early Periodic Screening, Diagnosis & Treatment (EPSDT)
- State Children's Health Insurance Program (SCHIP) (In NJ, this is Family Care-Children's Program)
- Temporary Assistance to Needy Families
- Children with disabilities & special health care needs



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.)



EPSDT

- Medicaid's comprehensive & preventive health program for children under 21
- Provides screening & services at medically-appropriate intervals
- Provides medically necessary health care services even if the service is not available under State's Medicaid plan
- States must inform all Medicaid-eligible persons under 21 that EPSDT is available



EPSDT screening

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



EPSDT additional screening (minimum 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 age 12 and 24 months
 - Children over 24 months if no record of previous test
 - Medically-necessary diagnostic & treatment services must be provided to children with elevated blood lead levels



NJ Family Care

- What's covered?
 - Doctor visits
 - Immunizations
 - Eyeglasses
 - X-rays, laboratory & other diagnostic tests
 - Prescriptions
 - Hospitalizations
 - Mental health services
 - Dental care for most children & some adults



NJ Family Care: Who's eligible

- Children 18 years old and under
- Family size & income eligibility (including working families): up to 350% of poverty for child eligibility
- No exclusion for pre-existing conditions
- Plan A Medicaid



NJ Family Care: Who's eligible

- Plan B: No premium or co-pay
- Plans C & D: Premiums & co-pays up to 5% of family income
- Immigration status: legal permanent resident or other qualified immigrant status regardless of date of entry



NJ Family Care: Who's eligible

- Waiting period: 6 months without insurance, except for those who are Plan A eligible (up to 133% FPL)
- Other exceptions for those up to 200% of FPL, if:
 - Covered by health insurance they purchased on their own
 - Paying for COBRA, or
 - Lost insurance through job loss/closure.
 - Exception for those up to 350% FPL if their COBRA has expired



NJ Family Care: What is it?

- Federal & state-funded health insurance program that helps uninsured children receive affordable health coverage
- Available based on family size and monthly income, not assets
- Not a welfare program
- For working families who cannot afford to buy health insurance privately



Split Application Medicaid

- Children with disabilities not income-eligible for Medicaid through SSI or otherwise because their parents' income has been "deemed to them" may be eligible if they have a sibling
- If has a sibling, both children apply for Medicaid under Medically Needy program
 - Parents' income is deemed to child without disability
 - Child with disability is now considered on his or her own and so will be income-eligible
 - Child with disability must meet SSI disability requirements
 - Resource limit of \$6000

Welfare, Supplemental Security Income & Medicaid



- If your family loses eligibility for welfare (Work First NJ 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!

Welfare, Supplemental Security Income & Medicaid



- For more information, consult the Medicaid Hotline at 1-800-356-1561
- Or your local county welfare agency in the blue pages of the telephone book



Medicaid Managed Care – 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 (SSI) and Medicaid; about 90,000 people



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 do so
- Families of children with complex medical or mental health needs may be allowed to continue with fee-for-service providers and not enroll in an HMO. Apply through HBC.
- Denials of exemption requests may be appealed through Medicaid Fair Hearing Process.



Exemptions to Medicaid Managed Care Enrollment

- 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 managed care:

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

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)



Federally Qualified Health Centers

- Over 1,000,000 patient visits are made to New Jersey's Federally Qualified Health Centers annually by almost 325,000 clients.
- Health care is available without consideration of ability to pay.



FQHCs

- 21 Community health centers and satellite sites
- Federally funded/qualified by Sections 330/329 of US Public Health Service
 - Located in Atlantic, Bergen, Burlington, Camden, Cumberland, Essex, Hudson, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Sussex, Union, and Warren counties
- Target the health care needs of the medically underserved within their respective service areas (urban, rural, high poverty).



Characteristics of FQHCs

- Governance by users of FQHCs and by local professionals.
- Locations in underserved neighborhoods with clinic hours that include nights and weekends.
- Utilization of National Health Service Corps physicians who are devoted on a full-time basis to the Center.
- Multilingual staff.
- Ability to provide multiple sites and even mobile clinics and services for rural populations.
- Commitment to offering a wide array of medical and supportive services.



Characteristics of FQHCs

- Provision of care at costs which are substantially lower than at other settings; sliding fee scales.
- Reduction of overall health care costs as an effective alternative to emergency room utilization.
- Physician admitting privileges in local hospitals to provide 24-hour care to patients.
- Networking with community-based human service organizations to provide a continuum of care.
- Programs are based on the life-cycle concept, which gives particular emphasis to maternal and child health and seeks to provide quality care for people from prenatal care to old age.



What do FQHCs offer?

- Primary & preventive care, including immunizations
- Transportation, translation, culturally competent care
- Dental care
- Well-baby care
- Health education services
- Disease screening & control



What do FQHCs offer?

- Emergency medical services
- Diagnostic laboratory & radiological services
- Referrals to substance abuse & mental health programs
- Case management of specialty & inpatient services
- Pharmaceutical services



Quick Facts about NJ FQHCs

- 19 FQHCs at 93 sites
 - 65 Primary care sites
 - 23 school based sites
 - 1 school linked site
 - 4 mobile units
- Types of centers
 - Community health centers
 - Migrant health centers
 - Health care for the homeless programs



Who uses FQHCs?

- Health insurance status
 - 43% uninsured
 - 45% insured by Medicaid
- Majority (>70%) are women & children



Finding a FQHC...

- Go to

<http://www.njpca.org/FQHC/directory.aspx>



NJ Charity Care

- Charity care is the state-mandated and state-funded program that reimburses New Jersey hospitals for treating people without health insurance who have no other means of paying for health care and who meet eligibility requirements. (Only people who meet certain criteria are eligible to receive charity care).



Charity Care

- Free or reduced charge care
- In patient & out patient services at acute care hospitals for “necessary hospital care”
- Funded under Health Care Subsidy Fund, PL 1997, Chapter 263



Who is eligible for Charity care

- NJ residents who:
 - Have no health coverage or have health coverage that pays only part of the bill
 - Are ineligible for any government sponsored coverage
 - Meet both income and assets eligibility criteria



How are eligible applicants notified?

- Hospital-posted signs
- Written notice to patients
- Multiple languages (English and any language spoken by at least 10% of the population in hospital's service area)



How to apply for charity care?

- Apply at the hospital business or admissions office
- Patient answers questions & provides documentation of income & assets
- Patient has up to one year from date of service to apply
- Call Health Care for Uninsured Program at 866-588-5696



For more information...

- Go to <http://www.state.nj.us/health/cc/index.shtml>
- NJ Legal Services Guide to Charity Care: <http://www.lsnjlaw.org/english/healthcare/uninsured/njcc/>



Advocacy

- An advocate pleads the case of another
 - When you advocate effectively to meet your child's needs, you may change a whole system to better meet other's needs
 - When you advocate effectively for all children with special needs, you may help make systems work better for your child and family



Advocating & Medicaid Managed Care

- Read Fact Sheet 3 for general principles of advocacy.
- **Enlist allies** – providers or parent support; take representation to formal hearings
- **Volunteer** for
 - HMO advisory boards
 - State agency consumer advisory groups
- **Ask** your elected officials to support policies that will help children with special health care needs
- Help your **child become a self-advocate** at whatever developmental level she's at
- **You are your child's best advocate**



Dispute Resolution

- To prevent disputes or misunderstandings:
 - Learn your Medicaid managed care or plan rights and responsibilities from your member handbook
 - If there is anything you don't understand, **ask** your PCP, care manager, or HMO member services
 - Try to resolve problems when and where they arise by talking openly with the person(s) involved
- You can file a complaint, grievance or appeal, or your PCP or another representative can do it for you, with your permission



You can file a grievance or appeal:

- If you have complaints about quality of care; or
- If you or a family member has had a covered health benefit denied, reduced or terminated.
- See member handbook for process.
- Try to resolve the problem as close to its origin as possible.



Dispute Resolution...

- If you can't prevent or immediately resolve a problem to your satisfaction, call HMO/plan member services and make a complaint. Be specific.
- If member services can't solve the problem in 24 hours, you may register a **grievance** with your HMO or plan by phone or letter
- If you are not satisfied with the HMO's solution, call the state Medicaid hotline or the MHCCAP helpline.
- Keep records of all contacts!



Appeals

- HMO must notify you in writing 10 days before it denies or limits covered services.
- You may file an appeal of the denial with your HMO.
- Sometimes appeals are resolved easily, but the process can become complicated, so you may want to turn to your care manager or to the Community Health Law Project or Legal Services of New Jersey for advice.



Appeals – stages

- Internal (within HMO or insurance plan): two stages
 - 1. With HMO/plan's medical director or MD who denied services
 - 2. With physicians not involved in 1st internal appeal who might care for children like yours
- External (if internal gives unsatisfactory results)
 - 3. To NJ Dept. of Health and Senior Services to refer appeal to an Independent Utilization Review Organization (\$2). IURO reviews case & (if it accepts it) issues a decision to you &/or your PCP, & your HMO.



Appeals ...

- At each stage, if the HMO/plan continues to deny services, it must inform you in writing within a specified time, giving you
 - reasons for denial and
 - how to proceed to the next stage
- At any time during the appeals process, you may also request a **Medicaid Fair Hearing**.
- Ask for an immediate review in any urgent situation!
- Keep good records of all interactions.



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
- Health Benefits Coordinator (HBC): 1-800-701-0720