



HOW TO BE YOUR OWN **BEST ADVOCATE**

A GUIDE ON HOW TO NAVIGATE MANAGED CARE IN IOWA

HOW TO USE THIS GUIDE

Health insurance can be complicated, and advocating for yourself can be intimidating. It is our hope that this publication will help you to navigate the managed care system on your own. This tool can serve as an educational resource and reference to you when you need specific answers and general information about the complex and ever-changing world of managed care. It is organized by chapters so you can easily find the topic of interest.

If you need further assistance after reading this guide, do not hesitate to reach out to an organization listed in the back.

Disclaimer: This information is intended to provide guidance and general information. No portion of this guidebook should be used as a substitute for legal advice. When specific situations arise, individuals should consult legal counsel.

WHO CONTRIBUTED TO THIS GUIDE

This publication was produced in partnership by the Managed Care Ombudsman Program, Disability Rights IOWA and Iowans with Disabilities in Action (ID Action).

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1

INTRODUCTION





On April 1, 2016, most Medicaid members in Iowa were enrolled in managed care and began receiving services from a managed care organization, also known as an MCO. With this change, there is a lot to learn in order for you to be your own best advocate. Let's start with the basics.

WHAT IS MANAGED CARE?

Managed care is simply a health insurance system that coordinates the care of patients to improve quality of care while reducing costs. An MCO is the health insurance plan in the managed care system that pays for and manages a patient's overall care and coordinates their care in a way that improves or maintains their health.

MCOs operate similar to private insurance here in Iowa. The goal is to improve quality of care and the health of managed care members in the most cost-effective way possible. Many states have moved their Medicaid program to managed care, which is becoming the most common system across the country.

AM I IN MANAGED CARE?

Managed care is not new in Iowa. Iowa's managed care program, IA Health Link, expanded managed care to include additional populations and services. To learn more, visit dhs.iowa.gov/iahealthlink. The program manages and coordinates care for Medicaid members receiving physical and behavioral health and long-term care services through MCOs. Currently, there are three MCOs that provide care to Medicaid managed care members. They are Amerigroup, AmeriHealth Caritas of Iowa, and United Healthcare.

Most Medicaid members are enrolled in managed care and will receive coverage from an MCO. To find out if you are a managed care member, contact Iowa Medicaid Member Services at 1-800-338-8366.

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MCO ENROLLMENT

HOW DO I GET STARTED WITH MY MCO?

When you are determined to be eligible for Medicaid and managed care, you are given a tentative assignment to a managed care organization (MCO). This may or may not be the best MCO for you. It is your responsibility to choose the MCO that is best for you. It is important that you make an informed decision when selecting your MCO. While all MCOs are required to provide baseline Medicaid benefits to their members, each MCO has a unique delivery system.

Each MCO has contracted with providers to deliver health and long-term services and supports. The word “provider” refers to a physician, hospital, nursing home, pharmacy, lab, or any individual or group that provides a health care service. These contracted providers are considered the MCO’s “network” of providers, and you are required to seek care from providers within the MCO’s network.

The word “provider” refers to a physician, hospital, nursing home, pharmacy, lab, or any individual or agency that provides a health care service.

WHEN SELECTING YOUR MCO, CONSIDER THE FOLLOWING:

- IS MY PROVIDER IN THE MCO NETWORK?
- IS MY PHARMACY IN THE MCO NETWORK?
- DOES THE MCO HAVE SPECIALISTS CLOSE TO MY COMMUNITY?
- DOES THE PLAN HAVE VALUE-ADDED SERVICES THAT WOULD BENEFIT ME?
- DOES THE MCO HAVE CALL CENTERS OR HELPLINES AVAILABLE BEYOND REGULAR BUSINESS HOURS?

There are several resources available to help you identify which MCO you should choose:

- **THE MCOs:** Contact the MCOs to ask questions and learn about their provider networks and other services they provide that might benefit you.
- **IOWA MEDICAID (IME) MEMBER SERVICES:** Contact and request Choice Counseling, a service that identifies which MCO your providers have contracted with and if there are any other considerations that may be helpful for you.
- **PROVIDERS:** Contact your providers to learn which MCO(s) they have agreed to work with.

As a managed care member, you will receive a paper copy of your MCO's member handbook. The purpose of the handbook is to help you understand your MCO's policies and procedures and know what is available to you through your MCO. It also provides you with important contact information and a place to keep a record of your providers. The MCO member handbook should be available in several versions, such as Braille and audio, and can be requested in different languages as well.

As an MCO member, you will have two ID cards: **1) Medicaid ID card** and **2) MCO ID card**.

It is important to keep your member handbook in an easy-to-access location. If you have a question about your MCO or would like information about a service, your member handbook is a great place to start.

It is important to keep both cards. Your MCO ID card will state your MCO, your MCO ID number, your Medicaid ID, and important phone numbers. It is important to note that your Medicaid number and your MCO ID number may or may not be the same. You must bring both cards to your health care appointments and provide them at check-in.

If you do not receive your member handbook or MCO ID card, contact your MCO member services. This number can be found on the back of your ID card, in your member handbook, and on the MCO's website.

HOW CAN I CHANGE MY MCO?

As a member, you are able to change your MCO throughout your managed care experience. You can change your MCO for the following reasons.

1 WITHIN 90 DAYS OF BECOMING ELIGIBLE

After becoming eligible for an MCO, you have 90 days to change your MCO for any reason. For example, if your MCO coverage starts on February 1, you are able to change your MCO for any reason until May 2.

2 DURING ANNUAL ENROLLMENT

You will have an opportunity each year to change your MCO during your annual enrollment period. You will receive a letter from IME to let you know when you are in your annual enrollment period. During this time, you may change your MCO for any reason, also known as "without good cause."

3 FOR A "GOOD CAUSE"

If you are past the first 90 days and are not in your annual enrollment period, you must have "good cause" to change your MCO. Examples of good cause are:

- Needing services from a provider within a different MCO's network
- Your MCO does not cover the services you need due to moral or religious objections
- Insufficient quality of care given by your MCO
- Inadequate treatment given for your medical diagnosis
- Inadequate use of referrals or specialty care providers
- Refusal to give referrals for second opinions
- Medical services provided in an untimely manner
- Availability of a new, previously unavailable provider who is enrolled with a different MCO



FOR EXAMPLE

WHEN WILL THE CHANGE BE EFFECTIVE?

After requesting to change your MCO, you will receive a confirmation of coverage letter that states the date you will begin receiving coverage from your newly chosen MCO. This is not an immediate change. You will continue to receive coverage from your current MCO until the change takes effect. For the specific dates related to your MCO change, contact IME Member Services.

Your effective coverage date will depend on the date that you request to make your change.

- *If you request to change your MCO on January 8, your coverage with your new MCO will begin February 1.*
- *If you request to change your MCO after the middle of the month, January 21 for example, your coverage with your new MCO will begin March 1.*
- *It is always best to contact IME Member Services to verify when your coverage will be in effect.*

CONTACT IME MEMBER SERVICES TO CHANGE YOUR MCO:



1-800-338-8366
Relay Iowa TTY at 1-800-735-2942



Request that an MCO enrollment form be mailed to you. The MCO enrollment form can be mailed, faxed, or scanned and emailed back to the IME.



imemberservices@dhs.state.ia.us

WHAT ARE MY RIGHTS AS A MEMBER?

It is important to be aware of your rights and responsibilities as a managed care member. Your member rights are listed in your member handbook and are in place to protect you as you work with your managed care organization (MCO). You have the right to:

- **Be treated** with respect and dignity and expect privacy and confidentiality
- **Express concerns** without fear of reprisal
- **Participate** in your care planning process and make decisions about treatment
- **Make** personal choices
- **Be fully informed** about services and costs
- **Receive** timely, appropriate, and accessible medical care
- **Access** emergency care services without prior approval if your health is in danger
- **Choose** the provider of your choice from the providers available with your MCO
- **Change** your MCO, as allowed by program policy
- **Receive** interpretive services
- **Appeal** a decision made by your MCO

WHAT ARE MY RESPONSIBILITIES AS A MEMBER?

Being an active participant in your care is one of the most important roles you play in ensuring you get the care you need when you need it. Your responsibilities are to:

- **Be knowledgeable** about your medical coverage
- **Receive** regular care from your health care providers
- **Contact** your provider before emergency room visits with the exception of situations requiring emergency care. *(See page 14 of the IA Health Link Member Handbook for the definition of emergency situations.)*
- **Carry** your current medical assistance card and MCO card at all times and present them when accessing medical care
- **Call** the number on the reverse side of your medical cards if you move or have incorrect information printed on your medical cards
- **Pay** for any medical bills if you do not present your Iowa Medicaid card or MCO card at the time of your visit
- **Pay** for any medical bills for services provided by a practitioner who is not participating in the Iowa Medicaid program or is not enrolled with your MCO

WHAT ELSE SHOULD I KNOW?

It is in your best interest to do the following:

- Maintain good records
- Notify your MCO of any changes in your health
- Open your mail in a timely manner
- Keep all mail including letters and the envelopes in which the letters were sent from IME and your MCO
- Update your contact information as needed with IME and your MCO
- Discuss your potential future needs with your primary care physician to help you plan for your future

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GRIEVANCES, APPEALS, AND STATE FAIR HEARINGS



The quality of care and services you receive are important to your everyday health. There may be times when you do not receive customer service or quality of service that meets your expectations from your managed care organization (MCO) or provider, or you may disagree with a decision made by your managed care organization. It is important to know your options for expressing dissatisfaction or concern with how you were treated or disagreement with a decision made about your care.

The following sections talk about formal ways to share your issue or concern. The general process is provided below.



It is important to stay in communication with your case manager and share any concerns or issues. You can also communicate your issue directly to your MCO by contacting your MCO's member services.



FILE A GRIEVANCE

You can only file a grievance about issues such as quality of care, concerns, poor customer service, and untimeliness. Grievances can be filed any time. The MCO must acknowledge receipt within three days and must make a decision within 30 calendar days.



FILE AN APPEAL

You can only appeal a decision that was made about your care, such as a reduction in services or the denial of an authorization for a requested service or prescription drug. Appeals must be filed within 60 calendar days from the date printed on the MCO's notice of decision. The MCO must acknowledge receipt of appeal within three days and must make a decision within 30 days.

STILL UNHAPPY?



REQUEST A STATE FAIR HEARING

You can request a state fair hearing if you have exhausted the MCO's internal appeal process and are still dissatisfied with the MCO's decision on your appeal. Requests for a fair hearing must be made within 120 days of the date that the MCO made the decision on your appeal.

GRIEVANCES

MY SERVICES HAVEN'T BEEN REDUCED OR DENIED, BUT I AM UNHAPPY WITH MY SERVICE OR HAVE OTHER CONCERNS. WHAT CAN I DO?

FILE A GRIEVANCE. A grievance is a complaint about something other than a change or reduction in your services. For example, you can submit a grievance if you receive poor care or customer service from your MCO or if you feel your rights are not being respected.

As a member, you, your provider, or your authorized representative may submit a grievance on your behalf with your written consent. If you need help completing forms or taking other steps in the grievance process, your MCO must provide you with any reasonable assistance.

HOW DO I FILE A GRIEVANCE?

MEMBER EXAMPLE

Beth changed MCOs to continue to receive a service from a provider. Her new MCO did not send her a copy of their member handbook. Beth contacted the MCO's member services and requested a member handbook, but Beth still did not receive a copy. Beth submits a grievance.

1 REVIEW YOUR MEMBER HANDBOOK.

Your member handbook will include specifics on how to file a grievance with your MCO. You may submit your grievance at any time.

2 KNOW WHAT YOU WANT TO TELL YOUR MCO AND BE AS DETAILED AS YOU CAN.


Include dates, times, and names if you remember them. If you have a letter from your MCO related to your reason for the grievance, keep it in a safe place to maintain the record.


ADVOCACY TIP *Ensure the information you submit is specifically related to your complaint.*

3 PICK YOUR METHOD.


Your grievance may be submitted to your MCO by telephone or mail.


AMERIGROUP

 1-800-600-4441
(TTY 711)

 Amerigroup Iowa, Inc.
Grievance and Appeals Department
4800 Westown Parkway, Suite 200
West Des Moines, IA 50266


AMERIHEALTH

 1-855-332-2440
(TTY 1-844-214-2471)

 AmeriHealth Caritas Iowa
Complaints and Grievances Department
ATTN: Complaints and Grievances
P.O. Box 7116
London, KY 40742

UNITED

 1-800-464-9484
(TTY 711)

 UnitedHealthcare
Grievance and Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

4 SUBMIT YOUR GRIEVANCE.

Refer to the process in your member handbook and be as detailed as you can. If you choose to call, make a record of the date, time, and name of the individual you spoke to. If you choose to mail, keep a copy of your letter and write down what day you sent it.

5 RECEIVE RECEIPT.

You will receive a letter from your MCO acknowledging your grievance within three business days from the date they received your grievance.

6 RECEIVE RESPONSE.

Your MCO will make a decision on your grievance within 30 calendar days from the date they received the grievance. MCO grievance decisions must be in writing.

ADVOCACY TIP *You or your MCO can have an extra 14 days if more information is needed and it is in your best interest. If your grievance is urgent, your MCO must make a decision as quickly as needed.*

I DISAGREE WITH A DECISION MY MCO MADE ABOUT THE SERVICES I RECEIVE. WHAT CAN I DO?

FILE AN APPEAL. An appeal is a request for your MCO to reconsider decisions made about your care. For example, if your service hours are reduced, denied, or terminated and you disagree with that action you should submit an appeal. You can appeal a decision from your MCO whether you receive verbal or written notice. However, time limits to submit an appeal do not begin to run until a required notice has been issued.

When an MCO makes a decision denying, reducing, or otherwise limiting your services, that decision is called an “adverse benefit determination” and the MCO must provide you with a written notice informing you of the decision. If the MCO’s action affects services you were previously authorized to receive, then the MCO must mail you notice of their decision at least 10 days before the decision is implemented.

Appealing an MCO decision can be challenging. As a member, you, your provider, or your authorized representative may submit an appeal on your behalf with your written consent. You have the right to legal representation, though assistance from an attorney is not required. However, it is highly recommended to have an advocate assist you if possible. The MCO must provide you with any reasonable assistance in completing forms and taking other steps in the appeal process.

MEMBER EXAMPLE

John receives care in his home to help him remain independent. Each week a home health aide visits John three times to assist with bathing and personal care. John receives a letter from his MCO stating that his home health aide will be visiting only one time a week instead. John submits an appeal with his MCO.

HOW DO I FILE AN APPEAL?

Follow the steps below to submit an appeal with your MCO. A sample letter is provided in Appendix A. See *MCO Member Appeal Sample Letter*.

1 REVIEW THE NOTICE LETTER FROM YOUR MCO DESCRIBING THEIR DECISION AND THEIR REASONING.

This notice will tell you how to appeal and will include important deadlines. Your member handbook also states the specifics of how to file an appeal. Note the date of the MCO letter and the postmark date on the envelope to determine when you need to submit your appeal. Your appeal must be submitted within 60 calendar days of the date on the notice of decision. You may also want to request to continue your benefits during the appeal process. This request must be made within 10 days of the date the MCO mailed the decision to you.

i ADVOCACY TIP *Always save important letters from your MCO, including the envelopes showing when the letters were mailed to you.*

i ADVOCACY TIP *If you want to maintain your services while you appeal, you need to act quickly. You must specifically request continuation of your benefits within 10 days of the date the MCO mailed the decision to you; otherwise the MCO’s decision can be implemented during your appeal.*

2 KNOW WHAT YOU WANT TO TELL YOUR MCO AND BE AS DETAILED AS YOU CAN.

The notice of decision from your MCO should include a stated reason for their decision. Prepare information that challenges that reason and include it in your appeal. For example, include copies of medical records that indicate your medical service is medically necessary. Include dates, times, and names if you can remember them. If you have a letter from your MCO related to your appeal, keep it in a safe place.

3 PICK YOUR METHOD. Your appeal may be submitted with your MCO by telephone or mail. If you choose to submit your appeal by telephone, you will need to follow up with a written appeal.

AMERIGROUP



1-800-600-4441
(TTY 711)



Amerigroup Iowa, Inc.
Grievance and Appeals Department
4800 Westown Parkway, Suite 200
West Des Moines, IA 50266

AMERIHEALTH



1-855-332-2440
(TTY 1-844-214-2471)



AmeriHealth Caritas Iowa
ATTN: Member Appeals
Member Appeals Department
601 Locust Street, Suite 900
Des Moines, IA 50309

UNITED



1-800-464-9484
(TTY 711)



UnitedHealthcare
Grievance and Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

4 SUBMIT YOUR APPEAL. Refer to the specific process in your notice of decision or member handbook. Keep a copy of your written appeal and write down what day you sent it.

ADVOCACY TIP *As a member, you have the right to examine your case file, including medical records and any other documents or records, during the appeal process. You also have the right to present evidence in person or writing.*

ADVOCACY TIP *Save any documentation showing when you submitted your appeal, such as postage receipts, certified mail receipts, or fax confirmations.*

5 RECEIVE RECEIPT. You will receive a letter from your MCO acknowledging your appeal within three business days from the date they received your appeal. Keep a copy of the letter and the postmarked envelope in which it was sent to verify dates.

6 RECEIVE RESPONSE. Your MCO will make a decision on your appeal within 30 days from the date they received the appeal. MCO appeal decisions must be in writing and must describe the action taken and the reason for the action taken.

ADVOCACY TIP *You or your MCO can have an extra 14 days if more information is needed and it is in your best interest.*

EXPEDITED (FASTER) APPEAL

If the standard process for an appeal could negatively impact your health or ability to maintain or regain maximum function, you may request an expedited appeal. To file an expedited appeal, call your MCO. You do not have to submit anything in writing for an expedited appeal; however you may submit documents to support your appeal by faxing them to the MCO. Your MCO must make a decision within 72 hours of receiving your expedited appeal.

CONTINUED BENEFITS

MCOs must continue to provide your benefits while an appeal is pending if the appeal is challenging a termination, reduction, or suspension of previously authorized services and you request continuation within the timeframe. If you would like to continue to receive your service(s) during your appeal, you must request continuing benefits within 10 days of receiving the decision, and you must have filed your appeal with the MCO within 60 calendar days from the date of the notice of decision (if the appeal is filed separately from the request for continuation of benefits). Service(s) provided to you solely as a result of a request for continuation during your appeal may have to be paid back if the MCO's decision is upheld.

DEEMED EXHAUSTION

If your MCO fails to follow the notice and time standards in the appeal process, you have the right to move on to request a state fair hearing with the Iowa Department of Human Services without first appealing at the MCO level. This is called deemed exhaustion.

NEXT STEPS

If you still do not agree with the final outcome of your MCO appeal, you have the right to request a state fair hearing with DHS.

I AM STILL DISSATISFIED WITH MY MCO'S DECISION ON MY APPEAL. WHAT CAN I DO?

REQUEST A STATE FAIR HEARING. A state fair hearing is an appeal to DHS, as it is the agency that oversees the Medicaid program. In a state fair hearing, you make your case before an administrative law judge. You and your MCO will have the opportunity to present evidence, including documents and witness testimony. Your goal is to show the judge that there is a medical need for the service or equipment you requested. The administrative law judge will review the evidence provided and will make a decision on your case.

HOW DO I REQUEST A STATE FAIR HEARING?


To request a hearing, follow the steps below. A sample letter is provided in Appendix B. See *Request for State Fair Hearing Member Sample Letter*.

1 TIMING OF THE REQUEST. You have 120 calendar days from the date on the MCO appeal decision letter to ask for a hearing. The written notice from the MCO should advise you about the right to request a hearing and how to do so.


2 REQUEST TO CONTINUE SERVICE(S). MCOs must continue to provide your benefits while a hearing appeal is pending if the appeal is challenging a termination, reduction, or suspension of previously authorized services; the period of the original authorization has not expired; and the member requests continuation of those services. If you would like to continue to receive your service(s) during your hearing appeal, you must request this within 10 days of receiving the MCO decision on your appeal.

i ADVOCACY TIP *If the judge upholds the MCO's decision, you may be responsible for paying for the service you received during the hearing process.*

3 PICK YOUR METHOD OF FILING AND SUBMIT YOUR REQUEST. It is recommended that you explain the service or issue you are appealing. Also state that you have either completed the MCO level of appeal or that you are entitled to "deemed exhaustion" due to notice or timing issues with the MCO appeal process. A sample written request for a state fair hearing can be found in Appendix B. Keep a copy of your written request and write down what day you submitted your request to the DHS Appeals Section. Your request for a hearing may be submitted with the DHS Appeals Section by phone, mail, or in person.

 DHS Appeals Section
1-515-281-3094

 Department of Human Services Appeals Section
1305 E. Walnut Street, 5th Floor
Des Moines, IA 50319

 www.dhs.iowa.gov. Complete an appeal form on the DHS website at dhs.iowa.gov.

4 RECEIVE RECEIPT. You will receive a letter from the DHS Appeals Section acknowledging receipt of your request for a state fair hearing.

5 REVIEW OF YOUR REQUEST. The DHS Appeals Section will review your request to determine if a hearing can be granted. If a hearing is granted, you will receive a notice of hearing. The notice of hearing will include the hearing date and time and will state the presiding administrative law judge. Most hearings are by telephone. If you would prefer an in-person hearing, your notice of hearing states how to make that request.



6

PREPARE FOR THE HEARING.

It is important to be organized, know your rights, and prove there is a medical need for your requested service or equipment. To prepare for your hearing, you should do the following.

GATHER DOCUMENTS. Organize any information or records that document the medical need for your requested service or equipment. If the service was reduced or discontinued in the past and had a negative effect on your health, be sure to gather any documents that show that effect.

REQUEST DOCUMENTS. You have the right to see all of the information in your file, including any information the MCO used when they made the decision to deny, terminate, or reduce the service. Contact your MCO to request a copy of your entire file. You want the entire file because, although the MCO will have used your most recent assessments to make their decision, the file may include past assessments that will help you show that the newest assessments do not reflect your needs today. Refer to Step 8 “Make your case” below for a checklist on witnesses and evidence.

SHARE DOCUMENTS. You are required to share the documents you plan to use during your hearing. The notice of hearing will tell you when and how to file your documents. The MCO is also required to share the documents they intend to use at the hearing. DHS may also submit an appeal summary. These documents are usually shared within five business days before the hearing date.

INVITE OTHERS. You should have medical professionals, such as your doctor, to help explain the medical need for the service you are requesting. Others involved in providing care, such as direct care workers, can also be good witnesses. If they cannot attend the hearing, they can write a letter explaining the medical need for the service.

7

ATTEND YOUR HEARING.

Your hearing will likely occur by telephone conference unless you requested an in-person hearing. It is your responsibility to call in for the hearing. You may call in as early as five minutes before your hearing is scheduled to begin. The judge will facilitate the hearing. You and the MCO will be given specific opportunities to state your case.

8 MAKE YOUR CASE.

This is your opportunity to explain to the judge why you need the service or equipment. It is important that you:

- Prove medical necessity
- State the type and amount of service you need
- Discuss how the service will or has helped you
- Show how your health is impacted if you do not receive the service

To make your case, you will need to present evidence and provide witness testimony. Present evidence that will help the judge understand what the requested service or equipment is and why you need it. Evidence can include:

- Testimony
- Records (medical, school, etc.)
- Documents (letters from your doctor, information about the service or equipment)
- Objects (any evidence other than witness testimony, records, or documents. For example, if you requested certain equipment, you could show the judge a picture of it.)

A Medicaid state fair hearing can only address the issue of the denial, suspension, reduction or termination of services. This is not the time to bring up other issues you have with the MCO or your service provider or any frustrations or dissatisfaction you have. It does not help your case to divert the judge's attention from the current issue at hand. It is better to stay focused.

Witnesses can include anyone who can speak to your medical need for the service or equipment. A witness should be able to describe the service and amount requested, its impact on your health, and the effect of not having the service. Consider the following to be witnesses:

- Physician
- Medical professional
- Provider
- Case manager
- Family
- Friends

Check your witnesses' schedules to make sure they are available on the day and time of your hearing. If a witness is only available to testify at a certain time or on a certain day, let the judge know that before the hearing date. If one of your witnesses is not available, that may be "good cause" for requesting a continuance (or a later hearing date).

9 RECEIVE THE DECISION.

The judge will make a decision about your case and issue a proposed decision. A decision will not be given during the hearing. You will be notified of the final decision within 90 days of the date of the appeal.

Both parties have appeal rights from the administrative law judge's proposed decision, so read the decision carefully for additional appeal rights. The proposed decision from the judge will provide more detail on this process.

Learn more about the state fair hearing process by reviewing information on the DHS website.

CAN I GET HELP WITH MY APPEAL?

Anyone you trust can help you during your hearing, such as:

- Physician
- Medical professional
- Provider
- Case manager
- Family
- Friends

You are also entitled to have legal representation at the hearing.

5

IMPORTANT TOPICS
AS A MEMBER

WHAT IS HELPFUL TO KNOW?

Navigating the managed care system can be complex. The following sections discuss topics that are especially important to your experience as a managed care member. These topics should help you get a better idea of what you should expect from your managed care organization (MCO). It is highly recommended that you have someone you trust to help you ensure that these expectations are met when it relates to your care.

PERSON-CENTERED PLANNING

As a member, the care you receive should be focused on you, your needs, and your preferences. You are the most important part of your care plan. This means that any assessments that are done to determine your care needs and build your service plan should accurately reflect your needs and preferences.

Person-centered planning helps to ensure that you have access to covered benefits and that your MCO monitors the services you receive to make sure your needs are adequately met. Your MCO should coordinate and share information with your community and natural supports and your service providers across the healthcare delivery system. Your MCO should also assist you to resolve any concerns about your service delivery or providers. If you change MCOs, your current MCO should communicate with your providers so that there is no interruption or delay in your services. If you receive waiver services, look to Appendix C to learn what your person-centered service plan should include.

Person-centered planning is a process directed by the member and intended to identify the strengths, capacities, preferences, needs, and desired outcomes of the individual.

PERSON-CENTERED PLANNING CHECKLIST

The person-centered planning process should include:

- Your contacts (legal or authorized representative, physician, family, case manager, etc.)
- Lead person to serve as your main point of contact
- Times and locations of your care
- Cultural considerations
- Strategies for resolving conflict
- Services and supports you receive and who provides them
- How to request updates to your care plan
- Alternative home and community-based settings
- Day activities, employment, and education opportunities



CASE MANAGEMENT

The role of your MCO case manager is to help ensure your needs, health, and safety are met. Your case manager can help you access resources within your MCO and community based on your needs and preferences.

Your case manager is responsible for working with you to develop a plan to meet your unique needs through Medicaid and managed-care-eligible services and supports. Your case manager can also coordinate access to your providers, identify community services, help you work with your MCO, and help you solve issues that you may have about your care.

Your case manager is a main point of contact with your MCO. Your case manager will make monthly contact either in person or by phone and is required to meet with you in your home every three months. You can call your case manager whenever you need to. Do not wait for your case manager to contact you.

i ADVOCACY TIP *Let your case manager know if you have a change in your health or needs. If you have an emergency or are hospitalized, let your case manager know once you are able.*

Your case manager has an important role in your quality of life and access to services. If you are unhappy with your case manager, you have the right to request a new one by calling your MCO member services. When you make your request for a new case manager, include why you would like a new case manager, and state any preferences you may have for your next case manager. Your MCO will take these things into consideration when assigning a case manager.

MEDICAL NECESSITY

Medicaid only provides services that are considered medically necessary. That means you will need to show that the service or equipment is a medical need. If you are a member that receives long-term services and supports through an MCO, you are able to use a variety of services to meet your health needs to ensure your quality of life. The role of the MCO is to partner with you to identify what services are needed and in what amount.

When a need is identified, the request for a service must go through an approval process within the MCO. During this process, the MCO assesses the service and amount requested to make sure they are medically necessary specific to your needs. The definition of “medical necessity” will likely depend on your age.

MEDICAL NECESSITY IS DEFINED by the state in its contract with the MCOs.

FOR CHILDREN UNDER THE AGE OF 21, the Medicaid Act defines medical necessity as “necessary health care, diagnostic services, treatment and other measures...to correct or ameliorate defects and physical and mental illnesses and conditions[.]”

MEDICAL NECESSITY FOR ADULTS is defined by the state in its contract with the MCOs. In Iowa, the covered services are reviewed for the following:

1. Appropriate and necessary for the symptoms, diagnosis, or treatment of the condition of the member
2. Provided for the diagnosis or direct care and treatment of the condition of member enabling the member to make reasonable progress in treatment
3. Within standards of professional practice and given at the appropriate time and in the appropriate setting
4. Not primarily for the convenience of the member, the member’s physician, or other provider
5. The most appropriate level of covered services that can safely be provided

The MCO must be objective during this process. However, the MCO relies on the information you and those assisting you provide them. To show that a service is medically necessary, it is important to communicate why that service is needed and to have evidence or documentation to support the need. Most often a physician will support why a member needs a covered service that is related to the health condition or disability. The MCO will consider individual information related to your medical and/or behavioral health and the availability of providers to meet your need.

MEDICAL NECESSITY CHECKLIST

- Include letters from all relevant healthcare and service providers
- Include previous treatments you have tried, what results they produced, and what led you to change them
 - Be specific
 - Include dates
 - State why you need the service



PRIOR AUTHORIZATION

Prior authorization (PA) is the process that your MCO uses to approve a request for a service or prescription. Not all of your services will need PA. If you have questions about PAs, it is best to first contact your MCO member services or your case manager.

If you and your provider determine that you would benefit from a service or prescription that requires a PA, it is the provider's responsibility to request a PA. The MCO, your provider, and you will follow the following PA process:

- 1 Your provider** gives the MCO information to show that the service or prescription is medically necessary.
- 2 The MCO** has a team that reviews the information using rules and guidelines from the Iowa Department of Human Services.
- 3 If the request is approved**, the MCO will let you and your provider know.
- 4 If the request is not approved**, a letter will be sent to you and your provider explaining the reason for the decision.

PAs must be handled within seven days, though most will likely be turned around in just a few days or less. Pharmacy PAs will be processed within 24 hours of the provider's PA submission.

Prior authorization is the process of obtaining approval as to the appropriateness of a service or medication.

If your MCO denies your request or approves it for less than what was requested, they must send you and your provider a letter explaining the following:

- The MCO's decision on the PA request
- The MCO's reasons for their decision
- Your right to file an appeal with the MCO
- How to file an appeal with the MCO and related information



LEVEL OF CARE

To receive long-term services and supports through your MCO, you are required to need facility level of care. The process of assessing if you are at a nursing facility level of care also identifies the services and supports needed to ensure your quality of life. This is done through a level-of-care assessment.

The level-of-care assessment is completed when you become eligible for Medicaid and then reviewed during your annual assessment. If your needs have changed and you need more services or a change in care setting, a reassessment may also be completed. Your MCO case manager should be involved in your level-of-care assessments and scheduling as well as any person you trust to ensure you communicate your needs clearly.

The level-of-care assessment is conducted by an agency contracted with your MCO. The individual completing the assessment will ask you a variety of questions about your health and ability to complete daily tasks. It is very important that you answer the questions correctly and fully describe your health status and abilities. For example, if you have the ability to dress yourself but it takes several hours to do so on your own, it's important to communicate that during your assessment.

You have the right to request a copy of your level-of-care assessment. Be sure to review your assessment and to make sure it was completed accurately before the agency leaves. If there is something on your assessment that you do not agree with, talk with your case manager and any others to discuss how to correct it.



EMERGENCY CARE

An emergency is when you need to get care right away for trauma, serious injury, and life-threatening symptoms. If you need emergency care, call 911 or go to the nearest hospital, regardless of whether the hospital is in your MCO's provider network. If it is a true emergency, you do not need to call your MCO first. Once you have received medical attention and if you are able, let your MCO and primary care physician (PCP) know that you visited the emergency room. Examples of emergencies:

- Chest pain
- Choking
- Severe wound or heavy bleeding
- Breathing problems
- Severe spasms or convulsions
- Loss of speech
- Broken bones
- Severe burns
- Drug overdose
- Sudden loss of feeling or not being able to move
- Severe dizzy spells, fainting, or blackout

NURSE LINE

If you have a medical question or would like advice about whether you need emergency care, you can contact your MCO's nurse line or on-call physician. The nurse line or on-call physician are resources available to give medical advice 24 hours a day, seven days a week from trained medical professionals. You can also contact your PCP. The phone numbers for your MCO's nurse line, on-call physician, and PCP are listed on your MCO ID card. These numbers are specific to your MCO and can also be found in your MCO member handbook under or near the emergency care section.



SECOND OPINIONS

Accurately identifying and diagnosing a complex health condition can be challenging for any provider, but getting it right is very important. There may be a time when you or your authorized representative have a question concerning a diagnosis or the options for surgery or treatment of a health condition. You may submit a request to your MCO to have a second opinion from a qualified professional within your provider network.

A second opinion is an opportunity for you to obtain a clinical evaluation by a qualified provider different from the provider who originally recommended a proposed health service to assess the clinical necessity and appropriateness of the initial proposed health service. Typically, second opinions are given by providers that are contracted with your MCO. However, if there is not a provider contracted with your MCO to provide a second opinion, then your MCO must arrange for you to obtain a second opinion from a provider outside of your network at no cost to you.

SECOND OPINIONS are an opportunity or requirement to gain an evaluation by a provider other than the one originally recommending a proposed health service. The purpose is to assess the necessity and appropriateness of the proposed health service.

ADVOCACY TIP

If you want a second opinion, ask your PCP to submit a request for you. This is at no cost to you. Once the second opinion is approved:

- *You will hear from your PCP*
- *Your PCP will let you know the date and time of the appointment*
- *Your PCP will also send copies of all related records to the doctor who will provide the second opinion*
- *Your PCP will let you and your MCO know the outcome of the second opinion*

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FURTHER ASSISTANCE



WHO ELSE CAN HELP ME?

This guide is intended to get you on the right path for navigating the managed care system. However, you might still have questions that have not been addressed. Below are additional resources available if you need further assistance.

MCO MEMBER SERVICES

As a managed care member, you have access to your managed care organization's (MCO) member services. If you have an issue, concern, or question about your care, your MCO should be your first point of contact. Your MCO's member services department includes a dedicated helpline staffed with trained individuals knowledgeable about your MCO and equipped to handle a variety of member questions. If member services is not able to directly assist you with your question or you would like to be connected with another MCO service, member services has the ability to transfer you directly. Member services is also available by email and mail and has services to communicate if you do not speak English, are deaf, or are hard of hearing.

Your MCO member services can answer questions about:

- MCO member handbook
- MCO member ID card
- Health care providers
- Health care benefits
- Utilization or health care management
- Wellness care
- Special kinds of health care
- Healthy living
- Grievances and appeals
- Rights and responsibilities

Communication with your MCO is an ongoing process. Your MCO should be aware of any changes in your health and in your providers as well as life changes and emergencies. Communicating with your MCO helps to ensure your services and health. If you have a question or problem or you need help, contact your MCO. If they are not able to help, ask them to get you connected to the right source or help you find the answer.

CONTACT



Amerigroup
1-800-600-4441



AmeriHealth
1-855-332-2440



United
1-800-464-9484

IOWA MEDICAID MEMBER SERVICES

Even though your MCO manages and coordinates your health care, Iowa Medicaid (IME) still has a role. IME Member Services is a customer service line equipped to assist you with questions specifically related to Medicaid. Customer service representatives are trained to provide assistance related to billing, address changes, Medicaid information, Medicaid ID cards, MCOs, and third-party liability. If you have a question related to Medicaid, IME Member Services is a great resource to use. If a representative is not able to answer your question or assist you directly, they will refer you to the appropriate resource(s). IME Member Services is also available by email and mail and has services to communicate if you do not speak English, are deaf, or are hard of hearing.

CONTACT



1-800-338-8366



imemberservices@dhs.state.ia.us

THE MANAGED CARE OMBUDSMAN PROGRAM

The Managed Care Ombudsman Program advocates for the rights and needs of Medicaid managed care members who live or receive care in a health care facility, assisted living program, or elder group home as well as members enrolled in one of Medicaid’s seven home and community-based services (HCBS) waiver programs, including:

- AIDS/HIV
- Brain injury
- Children’s mental health
- Elderly
- Health and disability
- Intellectual disability
- Physical disability

The Managed Care Ombudsman Program provides:

- Education and information regarding your rights as a Medicaid managed care member
- Advocacy and complaint resolution when you are unable to resolve an issue with your MCO
- Appeals assistance when you are dissatisfied with a decision made by your MCO about your care

CONTACT



1-866-236-1430



managedcareombudsman@iowa.gov

OFFICE OF OMBUDSMAN

The Office of Ombudsman serves as an independent and impartial agency to which citizens can submit their grievances about government. By facilitating communications between citizens and government and making recommendations to improve administrative practices and procedures, the Ombudsman promotes responsiveness and quality in government.

The Ombudsman has authority to investigate complaints about Iowa state and local government, with certain exceptions. The Ombudsman attempts to resolve most problems informally. Following an investigation, the Ombudsman may make findings and recommendations and publish a report. The Ombudsman may provide the following:

- Investigate a complaint against an agency, official, or employee of Iowa state and local government independently and impartially, and in a confidential manner, to the extent possible as provided by law
- Receive a complaint about Iowa Medicaid or your MCO
- Work with an agency to attempt to resolve a problem when an investigation shows that the agency has acted contrary to law, unreasonably or unfairly, or has made a mistake
- Make recommendations to agencies for administrative or policy changes, when appropriate
- Answer questions relating to government or refer a person to suitable agency or entity for answers

CONTACT



1-515-281-3592



www.legis.iowa.gov/ombudsman



DISABILITY RIGHTS IOWA

Disability Rights IOWA (DRI) is an independent nonprofit law firm that provides services to defend and promote the human and legal rights of Iowans who have disabilities and mental illness. The cases DRI accepts are based on the areas of focus set by DRI's board of directors. DRI may assist with issues such as abuse, neglect, discrimination, and denial of services.

CONTACT



1-515- 278-2502
Toll Free: 1-800-779-2502
Relay 711

www.



www.disabilityrightsiowa.org



info@driowa.org

IOWA LEGAL AID

Iowa Legal Aid is a nonprofit organization that provides critical legal assistance to low-income and vulnerable Iowans who have nowhere else to turn. Along with volunteer lawyers throughout the state, Iowa Legal Aid helps the legal system work for those who cannot afford help with legal issues.

CONTACT



1-515-243-1193

www.



www.iowalegalaid.org

IOWA STATE BAR ASSOCIATION

For additional information and referrals to attorneys who may be able to assist you, contact the Iowa State Bar Association.

CONTACT



(800) 457-3729



isba@iowabar.org

www.



www.iowafindalawyer.com



BUILDING
YOUR SUPPORT



WHY SHOULD I BUILD A TEAM OF SUPPORT?

A team of support and advocates can help you navigate the managed care system. Your team of support should consist of individuals who can offer practical and emotional support to maintain or improve your quality of life. The individuals in your support team should be trustworthy, reliable, and knowledgeable about you and your needs. Depending on your needs and experiences, your support team may change. Examples of when to call on your team of support:

- Identify resources
- Help with IA Health Link and managed care organization (MCO) communications
- Help you explain your needs
- Assist you in making decisions about your managed care experience
- Participate in your health care experience

WHAT IS AN ADVOCATE AND WHAT DO THEY DO?

The word advocate can mean different things, such as:

1. To speak in favor of
2. One who supports a cause
3. One who speaks on another's behalf
4. One who assists others to make decisions for themselves

For purposes of this guide, we are using the word to mean #4. An advocate is someone who helps you understand information that might be complicated.

WHY WOULD I WANT TO HAVE AN ADVOCATE?

- You don't understand something well enough to make a decision.
- You would like to talk about the decision you need to make before you make the final decision.
- You would like to find more information
- You would like help talking with others.
- You need help keeping track of papers and records.

An advocate can do lots of things that might be helpful to you, such as:

1. Write things down for you
2. Help you decide what questions to ask
3. Explain things to you
4. Find more information for you
5. Go to meetings with you
6. Talk to others with you (They shouldn't talk for you without you.)

AN ADVOCATE IS NOT THE PRIMARY DECISION-MAKER. YOU ARE!

WHO CAN I LOOK TO FOR SUPPORT?

- Family
- Friends
- Agencies
- Associations
- Advocacy organizations
- Case manager
- MCO

Create a list of the individuals that you would consider as your support team!





WHO CAN BE AN ADVOCATE FOR ME?

An advocate can be a lot of different people. Pick someone:

- 1** Who knows you well, understands you, and understands what you like and don't like
- 2** Who will help you but knows that YOU have to be involved in decisions about your life
- 3** Who can help you build positive relationships with people who serve you
- 4** Who will help you learn new skills and let you use them

ARE THERE OTHER WAYS TO PROVIDE INPUT AND ADVOCATE FOR MYSELF?

There are opportunities to share your experience as a managed care member.

IA HEALTH LINK PUBLIC COMMENT MEETINGS

- ▶ The Iowa Department of Human Services hosts public comment meetings to gather input on the IA Health Link managed care program. Meetings are held once per month in varying locations throughout Iowa.
- ▶ Call Iowa Medicaid Member Services to learn more.

MCO ADVISORY COMMITTEE

- ▶ Each MCO meets regularly with a group of members to discuss the MCO, member experiences, and various topics. This is an opportunity to learn more about the MCO, ask questions, and provide feedback to the MCO.
- ▶ Call your MCO member services and ask about the advisory committee.

LEGISLATORS

- ▶ Legislators want to know what is important to you. It helps them understand what you want or need so that they can assist you better. You can find your legislator at www.legis.iowa.gov/legislators/find.

APPENDIX A | MCO MEMBER APPEAL SAMPLE LETTER

[DATE]

[MANAGED CARE ORGANIZATION]

[ADDRESS]

Re: Appeal and Request for Continuation of Benefits

Dear Member Appeals Coordinator:

I am a Medicaid beneficiary and a current member of your managed care company. This letter is a request for appeal of [describe what it is you are appealing]. I also request that my benefits be continued while this appeal is considered.

BACKGROUND

I am diagnosed with [list all of your relevant medical conditions]. [Describe how your diagnosed conditions affect you, and include what services you receive to assist you with those conditions. Only include information that is relevant to the specific issue(s) you are appealing.]

[Include a short description of the issue(s) that you are appealing. Specifically list each decision the MCO has made that you disagree with and include dates if you can. Be sure to list every issue that you are appealing, or you may forfeit your appeal rights to unlisted issues.]

DISCUSSION

[Now describe your argument. Tell the MCO why their decision is wrong. Include detailed information on what negative impact the MCO's decision will have on you. Include information or opinions from your medical providers that support your argument if you have this information. Some of the following are common examples of issues:

A service reduction or termination will result in harm to your health and safety or will cause you to move into a health facility.

A service reduction or termination was not based on your medical needs.

An assessment used in the decision was incorrect, or your needs have changed.

Notice provided was insufficient or untimely.]

CONCLUSION

This is a request appealing [the issues described above]. I also request that my benefits be continued during this appeal.

Sincerely,

[Name]

Enc.: [Be sure to list any supportive documents you are submitting with your appeal].

APPENDIX B | REQUEST FOR STATE FAIR HEARING MEMBER SAMPLE LETTER

[DATE]

Department of Human Services
Appeals Section
1305 E. Walnut Street, 5th Floor
Des Moines, Iowa 50319

**CERTIFIED MAIL AND RETURN
RECEIPT REQUESTED**

RE: Request for State Fair Hearing
Client name, Medicaid No. [_____]

Member Appeals Coordinator:

I received a written letter dated [insert the date of your letter] from my managed care company, [list MCO name]. The MCO has reduced, suspended or terminated [state the MCO action here]. This letter is a request for a state fair hearing.

BACKGROUND AND REASON FOR APPEAL

[Describe yourself/person you are writing on behalf of and the factual circumstances here.]

EXHAUSTION OF MCO APPEAL PROCESS

[Member's Name] has exhausted the MCO appeal process. [Member's name] received an initial denial letter dated [list the month, day, and year] from MCO [write the name of MCO]. I appealed this decision in a letter dated [state the date of the letter]. On [state the date of denial] MCO [write the name of the MCO] again denied this claim. The reason cited for their decision was that the information reviewed [state reason for denial, e.g., fails to establish medical necessity for the requested service]. We disagree with the finding of the MCO that [restate reason, e.g., this device is not medically necessary].

Examples may include:

- ▶ Failure to meet language and format requirements, such as not receiving a denial in writing, lack of required content of notice, and the timing of the notice
- ▶ Failure by the MCO in handling of the grievance or appeal. An example is when a reviewer of the MCO appeal was the same person involved in previous level of review or is not a professional with appropriate clinical expertise. Another example is failure to provide the member a copy of the member's case file when requested.

[State if the individual wants their Medicaid benefits to continue pending the appeal process (must be requested within a 10-day timeframe of the date of notice on the MCO letter of decision).]

REQUEST FOR STATE FAIR HEARING

[State your name] requests a state fair hearing.

Sincerely,
[Name]
[Address] | [Phone number]

It is recommended that you list any other reason including inadequacy or timeliness issues with the notice of adverse benefit determination and appeal rights of individual.

APPENDIX C | SERVICE PLAN CRITERIA FOR WAIVER MEMBERS

WHAT SHOULD MY SERVICE PLAN INCLUDE?

As a member, you should be the leader in developing your service plan when possible. Your service plan should reflect the services and supports that are important to you to meet your needs identified through the needs assessment as well as what is important to you with regard to preferences for the delivery of such services and supports. The plan should address the full array of medical and nonmedical services and supports provided by your managed care organization (MCO) or available in the community to ensure the maximum degree of integration and the best possible health outcomes and satisfaction.

If you have a representative or a trusted loved one, you may allow them to participate in discussions with your MCO regarding your service plan. Your MCO should establish a team of providers brought together to discuss your service plan. You and the MCO team should work together to identify services based on your needs and desires as well as the availability and appropriateness of services. In case of an emergency, your MCO will work with the team to identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or when your needs change. If you receive care through a home and community-based services (HCBS) waiver, your service plan should:

- Include** your strengths and preferences
- Include** the clinical and support needs identified through your needs assessment as you discussed with your MCO team
- Include** your identified goals and desired outcomes that are observable and measurable
- Include** the interventions and supports needed to meet your goals and action steps
- Reflect** the services and supports, both paid and unpaid, that assist you to achieve your goals; the frequency of your services; and the providers of those services and supports, including natural supports such as a loved one
- Include** the names of providers responsible for carrying out any interventions or supports, including who is responsible for implementing each goal on the plan and the timeframes for each service
- Include** activities that encourage you to make choices that allow you to experience a sense of achievement, and to modify or continue participation in your service plan
- Reflect** the setting where you would prefer and choose to live
- Ensure** the setting that you choose allows you full access to the greater community and opportunities to seek employment and work environments if you choose
- Support** you in engaging in your community, controlling your own personal resources, and receiving services in the community to the same degree of access as individuals not on Medicaid receiving home and community-based services
- Include** a description of any restrictions on your rights, including the need for the restriction and a plan to restore your rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.
- Reflect** risk factors and measures in place to minimize them, including individualized backup plans and strategies when needed
- Include** a plan for emergencies
- Be** easily understood by you and written in plain language and in a manner that is accessible to you
- Identify** who is responsible for monitoring your plan
- Be** finalized and agreed to with your informed written consent and signed by all individuals and providers responsible for the implementation of your service plan
- Be** distributed to you and other people involved in your service plan
- Indicate** if you have elected to self-direct services and, as applicable, which services you elect to self-direct
- Prevent** unnecessary or inappropriate services and supports



Disability Rights IOWA
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