HEALTHY Times

A medical newsletter for health care professionals and caregivers of individuals with intellectual and other developmental disabilities

June 3, 2011, 22nd Annual Conference on Medical Care. Pictured LtoR: Thomas Baffuto, Executive Director, The Arc of New Jersey; Morning Keynote Speaker, Matthew Janicki, Research Associate Professor, University of Illinois at Chicago; Valerie Harr, Director, New Jersey Division of Medical Assistance and Health Services; Walter Bender, President, The Arc of New Jersey; Beverly Roberts, Director, Mainstreaming Medical Care Program, The Arc of New Jersey

22nd Annual Conference on Medical Care for Persons with Developmental Disabilities

The Arc of New Jersey's Mainstreaming Medical Care Program's **22nd Annual Conference on Medical Care for Persons with Developmental Disabilities**, once again, welcomed a variety of professionals for an informative day of keynote speeches and workshops on relevant and timely topics of interest to those who work with people with intellectual and developmental disabilities. On Friday, June 3rd, at the Westin Hotel in Princeton, an audience of more than 300 doctors, dentists, nurses, direct support and administrative professionals, New Jersey Department of Human Services (DHS) personnel and HMO representatives attended this highly anticipated event.

Dawn Hall Apgar, Deputy Commissioner of the New Jersey Department of Human Services and Acting Director of the Division of Developmental Disabilities opened the Plenary Session. Dr. Apgar spoke briefly about current events in the Division, as well as anticipated changes. The morning continued with an engaging Keynote presentation by Matthew P. Janicki, Ph.D., a Research Associate Professor of Human Development at the Institute of Disability and Human Development and the Director of Technical Assistance for the Rehabilitation Research and

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Major Changes in NJ's Medicaid System

Beverly Roberts

NJ Medicaid is requiring that everyone who has Medicaid – including people who also have Medicare or private health insurance – must enroll in a Medicaid HMO. A summary of NJ's Medicaid managed care requirements and safeguards are discussed below, with more detailed information and the latest updates, available on the Mainstreaming Medical Care Program's webpage: www.mainstreamingmedicalcare.org Our webpage can also be accessed from The Arc of NJ's website: www.arcnj.org I will be doing some presentations on the Medicaid managed care changes starting in September, as well as one or two Webinars. Please see our website for further information.

It is important for everyone to know that all of the health care benefits that were covered under the previous Medicaid system (known as fee-for-service) will continue to be covered.

NJ's Medicaid managed care enrollment is in two phases:

Phase 1 Enrollment: Most people with developmental disabilities who have Medicaid-only or who have private health insurance in addition to Medicaid were required to be in a Medicaid HMO as of August 1, 2011. If they did not choose an HMO, they were randomly auto-assigned. People on the Community Care Waiver (CCW), unless they also have Medicare, were required to enroll in Phase 1.

Phase 2 Enrollment: The dual eligibles (people who have both Medicare and Medicaid) are required to enroll in a Medicaid HMO in Phase 2. Medicaid beneficiaries who have Medicaid waivers *other than the CCW* will enroll in Phase 2. These waivers are:

1. AIDS Community Care Alternatives Program (ACCAP)
2. Community Resources for People with Disabilities (CRPD)
3. Global Options for Long-Term Care (GO)
4. Traumatic Brain Injury (TBI)

The deadline for Phase 2 individuals to choose a Medicaid HMO is September 15, 2011.

To choose an HMO you may call a NJ Medicaid/FamilyCare Health Benefits Coordinator at **1-866-472-5338 (TTY 1-800-701-0720)**. Anyone

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The Arc of Essex County Health Monitoring Project

Scott Feingold

Last July, The Healthcare Foundation of NJ awarded The Arc of Essex County $46,174 for a yearlong project entitled, Health Monitoring for Seniors with Developmental Disabilities. The funding is being used to provide daily on-site nursing support services to The Arc of Essex County's Adult Senior Center, Avenues. As we examine the effect that this year long project has had, The Arc of Essex County couldn't be more pleased with the positive outcomes resulting from this generous grant.

A nurse spends four hours a day at the Avenues program. In the beginning of the year, an initial medical assessment was completed for each individual that attends the program, in order to help establish baseline health markers. This was done by speaking with the staff, reviewing the annual physical, and doing a head to toe assessment of the individual. Once the initial assessments were completed, recommendations were made and followed up on. After the initial assessments, the seniors have benefitted from weekly health checks by the nurse. This has allowed the nurses to note any health changes and ensure proper care as soon as symptoms become apparent.

The nurse has also used this health information to develop individual health maintenance goals that have become part of the annual individual habilitation plan (IHP). The center has developed a new healthy living image. The seniors that attend the program are exercising more and eating healthier snacks. Whether it is getting up and moving by playing a game on the Wii, partaking in a movement class, or simply making an effort to walk around the center more throughout the day, this group is active and more energetic.

Families have also expressed their satisfaction with the grant. The nurses have helped to clarify medication questions and provided support to families with medical issues facing their family member. These relationships have helped earn the trust of family members when dealing with medical issues. The nurse has even attended relevant doctor's appointments with families in an effort to help provide an overall health picture to medical personnel. Rather than just reporting on how an individual is acting at home, the nurse is able to discuss problems that the family may not be seeing during the day.

Along with the health monitoring, the nurse holds training sessions for agency staff with topics related to senior health issues. Topics have included Alzheimer's and Dementia, Dysphagia, Diabetes Management, Walkers and Wheelchairs, and Aging and related changes. Staff members have found these trainings helpful and informative. Information is also sent home with individuals for their residential providers and families to have and learn from.

This grant has been a great step forward in helping to monitor the senior population with developmental disabilities. It has helped provide necessary health monitoring and helped to ensure continuity of care. By taking a proactive approach, it is The Arc's hope that these seniors can continue attending the program longer and living healthier lives. Recently, The Arc was funded for a second year of this grant. Along with continuing to monitor individuals at the Avenues program, the nurses will monitor an additional 26 individuals at other day programs who are beginning to show signs of aging.

The Arc of Essex County is extremely grateful to the Healthcare Foundation of NJ for this ground-breaking opportunity. Senior related issues are new to our field, and this grant is assisting us in creating best practices in serving seniors with developmental disabilities. It is our hope that this close monitoring will help us plan for and identify any health related issues that may arise as early as possible, and help families answer any questions that they may have.

For further information or questions about the Health Monitoring Project, please contact Scott Feingold at (973) 535-1181 ext. 1229 or via e-mail at sfeingold@arcessex.org.

The Arc of New Jersey

Healthy Times is a publication of Mainstreaming Medical Care, a program of **The Arc of New Jersey** funded by the New Jersey Division of Developmental Disabilities. To view or print copies of current and past issues, please visit us on the internet at:

www.mainstreamingmedicalcare.org

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We welcome comments and suggestions for future articles, and readers are encouraged to re-print or excerpt articles; please credit *Healthy Times* and **The Arc of New Jersey**, and forward copies to:

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Training Center in Aging with Developmental Disabilities at the University of Chicago at Illinois. Dr. Janicki presented an excellent review of the challenges persons with developmental disabilities will confront as they age and offered suggestions on how we can help them age-in-place successfully. Dr. Janicki's morning Keynote was followed by an informative update by Valerie J. Harr, Director of the New Jersey Division of Medical Assistance and Health Services, on the upcoming Medicaid managed care changes.

After lunch, David O'Hara, Ph.D., Chief Operating Officer at the Westchester Institute for Human Development in Valhalla, NY took the podium for an engaging afternoon Keynote presentation on a new technology being used at the Institute to help persons with developmental disabilities use telemedicine and eHealth strategies to promote good health as they age.

In addition to the keynote presentations, attendees were offered a selection of eleven workshop topics, from which registrants could select two. The feedback from those in attendance has been extremely positive, with 96% of responders reporting that they would recommend the Conference to their colleagues.

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who is required to enroll in a Medicaid HMO and does not choose will be randomly auto-assigned. The Phase 2 HMO enrollments will be effective on **October 1, 2011**. Previously, NJ Medicaid had a process to obtain an exemption, allowing individuals with complex medical needs to stay in the Medicaid fee-for-service system. But that policy ended, and currently no exemptions are allowed.

Switching to Another Medicaid HMO

Anyone who is newly enrolled in a Medicaid HMO and wants to change is allowed a period of 90 days from the date of enrollment to switch. After that time, enrollees can change HMOs once a year, during the Open Enrollment Period, which is from October 1 to November 15. The new HMO enrollment will take effect on January 1. However, enrollees have the option of changing HMOs at any time, if there is a "good cause" reason, by calling NJ Medicaid/FamilyCare at **1-800-701-0710 (TTY 1-800-701-0720)**.

"Carve-in" vs. "Carve-out"

Many types of health services that were previously covered under Medicaid fee-for-service ("carved-out" from the Medicaid HMO system) are now provided by the Medicaid HMOs ("carved-in"). In some cases, the provider of the services (e.g., the supplier of incontinence products) may change, but the services have not been eliminated. These are the health services for people with disabilities that are now covered by the Medicaid HMOs:

- The Pharmacy benefit
- Home health care
- PT, OT, and speech therapy
- Personal Care Assistance. Note: The Personal Preference Program (PPP) will still be covered by Medicaid fee-for-service.
- Adult and Pediatric Medical Day Care

Mental Health Services

Mental health services for individuals who are registered with the NJ Division of Developmental Disabilities (DDD) are **carved-in** to the Medicaid HMO system, i.e., provided by the HMO. Mental health services for non-DDD individuals are **carved-out**, i.e., provided by the Medicaid fee-for-service system. However, **partial care and partial hospital services are carved out for all Medicaid beneficiaries, including persons with developmental disabilities**. This is the same as the previous Medicaid policy. The Medicaid HMO's care manager should assist DDD consumers who need to locate new mental health providers. (See the paragraph below on care management services.)

Care Management Services

Care management services, usually provided by nurses, are available at all of the Medicaid HMOs. *Please note: Care Management is not the same as Member Services.* When done properly, care management is a very helpful service, especially for members with disabilities. Upon enrolling in the Medicaid HMO, every new member with a disability should receive a letter with information on the name and phone number of their care manager. Newly enrolled individuals with developmental disabilities should be contacted by a care manager who will do a Complex Needs Assessment. However, Medicaid HMO members with disabilities do not need to wait for the letter to arrive. They can reach out to a Medicaid HMO care manager using the phone numbers below.

Care managers are also able to do individual, out-of-network contracting with medical, dental, and mental health providers who are not in the HMO's network, when the HMO does not have in-network providers with the same level of expertise (e.g., in treating the complex needs of a person with a developmental disability) as the out-of-network provider. These arrangements are made on a case-by-case basis, if the health care professional is willing to make such an arrangement.

Medicaid HMO care management phone numbers

Amerigroup Community Care

Toll-free: 1-800-452-7101 extension 66050
Toll call: 732-452-6050

Healthfirst NJ

Medical Management, Toll-free: 1-866 467 7178

Horizon NJ Health

Toll-free: 1-800-682-9094 ext. 89385 (special needs line)

United Healthcare Community Plan

Toll-free: 1-877-704-8871, ext. 5260

Continuity of Care

For newly enrolled HMO members, there will be a continuity of care period during which the individuals will be able to continue to see their current providers – *even if those providers are not in the HMO's network.* However, the length of the continuity of care period will vary from person to person, depending on the complexity of the individual's health care problems and the availability of in-network health care providers with the expertise to provide the necessary medical, dental or mental health care. *When the HMO determines that the continuity of care period is ending for a particular person, and the enrollee with a developmental disability needs to switch to an in-network provider, the HMO's care manager should provide assistance in selecting an in-network provider who can meet the person's needs.*

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Dental Care
Dental care continues to be a benefit that is covered by the Medicaid HMOs, including general anesthesia in a hospital operating room, when medically necessary. The HMO's care manager should be contacted for assistance if there is difficulty locating dentists with the necessary expertise.

Durable Medical Equipment (DME) and Supplies
DME and supplies, including incontinence supplies, are covered by the Medicaid HMOs. The HMO's care manager should be contacted for assistance if there is difficulty locating these providers.

The Pharmacy Benefit – Prescription Drugs
Note: Persons who have private health insurance and Medicaid, see the heading below..
Also Note: The dual eligibles (people receiving Medicaid and Medicare) will continue to receive their medications from Medicare Part D.

Every Medicaid HMO has a formulary (a list) of medications that it will cover. Because each Medicaid HMO has its own formulary, some medications that are covered on one HMO's formulary may not necessarily be covered by another HMO. In general, the generic medications will probably be covered by all HMOs. Some brand name medications may have a prior authorization requirement in which the prescriber must document the necessity for that particular medication. However, Medicaid personnel have assured the advocates that there will be *a continuity of care period, and the consumers' current medications will continue to be covered by the HMO – regardless of the formulary requirements -- until an HMO care manager completes a complex needs assessment. The care manager will discuss any medication changes with the caregiver or consumer*.

Anticonvulsant Medications
- The Medicaid HMOs will cover **the anticonvulsant drugs that the enrollees with disabilities were taking before the pharmacy benefit carve-in started, even if the drugs are not on the formulary of the Medicaid HMO. This includes people who have been taking a brand name anticonvulsant medication and for whom it is medically necessary to have the brand of an anticonvulsant drug instead of a generic.**
- However, after enrolling in the Medicaid HMO, if the consumer needs to switch to a different anticonvulsant, the doctor will need to abide by the Medicaid HMO's formulary, recognizing that there is an appeals process for situations in which the HMO does not approve a particular non-formulary drug that the doctor states is medically necessary.

Medications For Mental Health Disorders
- In almost all cases, psychotropic medications, when prescribed by mental health professionals, (not primary care providers) will be covered by the Medicaid HMOs, for mental health disorders.
- The Medicaid HMOs will also cover the psychotropic medications that the enrollees with disabilities were taking before the pharmacy benefit carve-in started, even if the medications were prescribed by a primary care physician.
- However, after enrolling in the Medicaid HMO, if the consumer needs to switch to a different psychotropic medication, the doctor will need to abide by the Medicaid HMO's formulary, recognizing that there is an appeals process for situations in which the HMO does not approve a particular non-formulary drug that the doctor states is medically necessary.
- The HMOs will do "safety edits", which means they will investigate any prescribing practices in which a Medicaid HMO member has been prescribed dangerously high amounts of medication, or if they are taking multiple antipsychotic medications that may be dangerous.

People with Disabilities who Have Both Private Health Insurance and Medicaid
Many individuals with developmental disabilities have had private health insurance as their primary payer and Medicaid *fee-for-service* as their secondary payer. Medicaid HMOs will replace traditional Medicaid fee-for-service as the secondary payer when these individuals enroll in a Medicaid HMO.

This is the pertinent information for people with both private health insurance and Medicaid:
- Private health insurance is always the primary payer.
- After a provider with the private health plan bills that plan and the bill is paid, the provider will submit a claim for the unpaid balance to the Medicaid HMO. In the past, if the provider was not also a Medicaid provider, the Medicaid fee-for-service claims system was unable to pay the provider because the provider was not set up in the system.
- However, the Medicaid HMO *will* be able to process claims of providers who are not in their claims system(or network). The HMO will pay the difference between the amount paid by the private health plan and the approved rate for the service under the HMO coverage, if any. If the Medicaid HMO does not pay any part of the claim and the provider is not in the HMO network, the provider may send a bill for the balance. If the provider is in the Medicaid HMO network, the provider may not balance bill.
- If there is a service that the private health insurer does not cover (e.g., adult diapers, home health care), then the network of the Medicaid HMO must be used.
- *Prescription Medication*: The formulary of the private health insurer is primary. The Medicaid HMO should cover the co-pay – regardless of the amount of the co-pay -- even when the medication is not on the Medicaid HMO's formulary.

NJ Medicaid is developing a booklet for people who have both private health insurance and Medicaid, and it will have a section for people who also have Medicare. The booklet should be very helpful, and it will be available in September or October, 2011. As soon as it is completed, it will be available on the NJ Medicaid and The Arc of NJ websites.

What if the Medicaid HMO terminates, denies, or reduces a particular health care service? What are the consumer's rights?
If your HMO denies or limits a particular medical service, you have the right to appeal that decision. If you want to appeal your HMO's decision, you or your representative (or your health care provider, with your written consent) have two types of appeal that are available to you. One type of appeal is an HMO plan process appeal. The vast majority of persons with DD also have the right to request a Medicaid fair hearing. You can request either of the appeals or both of these appeals. If you choose to begin with the plan process appeal, you can leave that appeal process at any stage and pursue the Medicaid fair hearing process instead.
Plan Process: You can request a stage 1 appeal within 60 days of the date of the denial letter. To request a Stage1 appeal, you can call or write

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to your HMO. If you begin this stage with a phone call, you must follow your phone call with a letter. If you are currently receiving services that you want to continue during the appeal, you must request the continuation of benefits in writing to the HMO within 10 days of the mailing of the letter terminating or reducing the service. If your HMO reviews your Stage 1 appeal request, and you are not satisfied with that decision, you can request a Stage 2 appeal. You must request a Stage 2 appeal within 60 days of the denial letter. (Some HMOs allow up to 90 days to appeal) Again, if you request by phone, you must follow your phone call with a letter to the HMO. If you are not satisfied with the HMO's decision after the Stage 2 appeal, you have the right to request a Stage 3 external appeal. To request a Stage 3 external appeal, you must complete some forms and send a filing fee of $2.00, payable by check or money order to the "New Jersey Department of Banking and Insurance" within 60 days of receipt of the denial letter. You can request an expedited resolution of your appeal.

Fair Hearing: The vast majority of Medicaid recipients with a developmental disability have the right to request a Medicaid Fair Hearing at any time. A written request for a Medicaid Fair Hearing must be made within twenty (20) days of the date of the denial letter. If you want to continue receiving services during the appeal, you will need to request this again within ten days of the mailing of the most recent denial letter from the plan process. After you request a fair hearing, you will be contacted by the New Jersey Office of Administrative Law that it has received the appeal, and then when a date for the fair hearing has been scheduled. You will have the opportunity to present your case before an independent Administrative Law Judge at the fair hearing.

Frequently Asked Questions (FAQs) about Medicaid Managed Care were prepared by NJ Medicaid and are available online at: http://www.state.nj.us/humanservices/dmahs/home/Medicaid_Client_FAQs.pdf

NJ's Dual Eligibles are Required to Enroll in a Medicaid HMO

As mentioned in the previous article, the deadline for NJ's dual eligibles (people with both Medicare and Medicaid) to choose a Medicaid HMO is **September 15, 2011**. If they do not choose by that date, they will be randomly auto-assigned for an **October 1st** start date.

This is the pertinent information for dual eligibles who are enrolling in a Medicaid HMO:

- Medicare is always the primary payer.
- Dual eligibles can continue to see any provider who accepts regular Medicare, even if the provider is not in the Medicaid HMO network. This pertains to physicians, mental health providers, hospitals, durable medical equipment, etc.
- If there is a service that Medicare does not cover (e.g., ***dental care***), then the network of the Medicaid HMO must be used.
- Medicare usually pays 80% of the cost of an office visit. The amount Medicare pays plus the amount that the Medicaid HMO pays (if anything), is to be considered "payment in full" for Medicare-covered services provided to duals in accordance with Section 1902(n)(3)(A) of the Social Security Act. Also, under federal regulations, Medicare providers may not accept dual eligible patients as "private pay" in order to bill the patient directly.
- If the prescription medication is currently covered by Medicare Part D, this will continue.

Dual eligibles and the Issue of Coinsurance for Medical Visits

Medicaid fee for service has historically paid only up to the Medicaid maximum for a cross-over claim. For example, if the charge was $80.00 and the Medicare payment was $64.00 (80% of the charge), **Medicaid** would pay the 20% coinsurance or the difference between the Medicare reimbursement and the Medicaid rate, whichever is less. In this example, let's say the **Medicaid** rate is $70.00. In that case, **Medicaid** would pay $6.00 toward the bill (The difference between the $70 Medicaid rate and the amount Medicare paid $64 = $6.00). The recipient is not responsible for any additional payment. If the Medicaid rate is lower than the Medicare 80% payment, no Medicaid payment is made to the Medicare provider. As long as the recipient has informed the provider of Medicaid status, the recipient is not responsible for a coinsurance amount.

Medicare reimbursement for hospital-based care has a different methodology for payment than the typical 80% Medicare payment and 20% coinsurance amounts. After Medicare pays for hospital-based care, Medicaid will pay the deductibles and coinsurance amounts for that care. The Medicaid HMOs will follow the same "rules" that Medicaid fee-for-service did in determining the payment of the coinsurance amount. In other words, for the dual eligibles, the Medicaid HMO will cover the same coinsurance amount, using the same formula that Medicaid fee-for-service had paid.

Prescription Drug Co-Pays for Dual Eligibles

As of July 1, 2011, NJ's dual eligibles (people with both Medicare and Medicaid), whose prescription drugs are covered by Medicare Part D are required to have prescription co-pays. (There are no drug co-pays for Medicaid-only individuals.) For most dual eligibles with developmental disabilities, the **drug co-pays are $1.10 for each generic and $3.30 for each brand name drug.**

When the annual cumulative cost of drugs received by an individual dual eligible reaches $6,477.50, then there is a $0 co-pay, for the remainder of that calendar year. The other aspects of Medicare Part D coverage for dual eligibles are unchanged: no monthly premium as long as the dual eligible is enrolled in a benchmark drug plan and no deductible. The new medication co-pays for dual eligibles are occurring because the state of NJ had been covering these costs, but that coverage ended on June 30th.

There is some good news for dual eligibles who are on the Community Care Waiver (CCW): Starting on January 1, 2012, dual eligibles with developmental disabilities who are on the CCW and receive prescription drugs from Medicare Part D will not have any medication co-payments. This change is due to a new regulation at the federal level.

Note: Some people have three types of health coverage: private health insurance, Medicare and Medicaid. If their medication is currently covered by private health insurance (not by Medicare Part D), then the medication co-pays will be covered by Medicaid. This will continue as long as the prescription medications are covered by private health insurance.

HELPFUL RESOURCES

MEDICARE'S QUALITY CARE FINDER

Medicare has a new online resource available at: **www.medicare.gov/qualitycarefinder.**

The Quality Care Finder is a helpful resource for consumers and their loved ones to access all of Medicare.gov's compare tools so they can get information that will help put them in control and feel more confident about the healthcare decisions they make.

It is a collection of current Medicare.gov and HHS.gov tools that make it easy to find health care providers, facilities, suppliers and more in specific geographic areas, and then make "apples-to-apples" comparisons of their quality.

Available resources for consumers include:

Hospital Compare: Compare Medicare-certified hospitals locally and throughout the country based on the quality of their care.

Nursing Home Compare: Find Medicare-certified nursing homes and the special services each nursing home offers, like dementia care, ventilators or rehabilitation. Then compare their star ratings and the quality of care they give.

Home Health Compare: Find Medicare-certified home health agencies based on services like skilled nursing care, physical therapy, speech therapy and home health aides. Then, compare each home health agency based on the quality of their care.

Medicare Plan Finder: Get detailed, personalized information about the cost and benefits of available Medicare health and drug plans, and compare the quality of the services they provide.

Dialysis Facility Compare: Find Medicare-certified dialysis facilities and their services. Then, compare each facility based on quality of care.

Physician Compare: Find doctors based on medical specialty, clinical training, foreign languages spoken, and more. Check to see if a doctor accepts the Medicare-approved amount as full payment.

Comparing Is Easy

You can access the information online or call 1-800-MEDICARE (1-800-633-4227) to find and compare health care providers. TTY users should call 1-877-486-2048.

A FORM TO REPORT MEDICAID HMO PROBLEMS

The Mainstreaming Medical Care program has developed a new form for reporting Medicaid HMO problems. Individuals with developmental disabilities and/or their caregivers who are enrolled in a Medicaid HMO and experiencing problems with the transition to managed care, OR dual eligibles (people with both Medicaid and Medicare) who are having problems with the new Medicare Part D co-pay, can use this form to report any problems and make a request for The Arc of New Jersey to advocate on their behalf.

A link to the form can be found on our website at ***www.mainstreamingmedicalcare.org***. Please complete the form, save it (using your last name) and e-mail the report form with details of the problem to **broberts@arcnj.org** or **hrivera@arcnj.org**. You may also print out the form and fax it to us at **(732) 214-1834**.

We are tracking the issues and problems as they occur, and, with permission from the consumer/legal guardian, will forward your e-mail to Medicaid, because they want to be aware of the problems that arise.

ATTENTION

Medicaid and Medicare

If you have both **Medicaid** and **Medicare**, or if you are in one of these Waiver Programs:

- **AIDS Community Care Alternatives Program (ACCAP)**
- **Community Resources for People with Disabilities (CRPD)**
- **Global Options Waiver (GO)**
- **Traumatic Brain Injury (TBI)**

You MUST select a Medicaid/NJ FamilyCare health plan by September 15, 2011 for enrollment effective October 1, 2011 or you will be assigned to one and notified by mail.

The following four (4) health plans participate in the Medicaid/NJ FamilyCare program:

- **Amerigroup Community Care** *(Serving all counties except Salem)*
- **Healthfirst Health Plan of New Jersey** *(Serving Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union counties)*
- **Horizon NJ Health** *(Serving all counties)*
- **UnitedHealthcare Community Plan** *(Serving all counties)*

Call 1-800-701-0710 (TTY # 1-800-701-0720) for help in selecting your Medicaid health plan

Prepared by DHS Office of Publications 7/11

This flyer was prepared by the NJ Department of Human Services and is also available in Spanish. Please contact Helen Rivera at hrivera@arcnj.org or 732-246-2525, x35 if you would like a Spanish version of this flyer, or if you would like the full color version emailed to you.

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Mainstreaming Medical Care is a special program of The Arc of New Jersey

Advocating for quality health care for individuals with intellectual and developmental disabilities

IMPORTANT NOTICE FOR ALL NJ MEDICARE PROVIDERS

NJ's dual eligibles (people who receive both Medicare and Medicaid) will be enrolled in a Medicaid HMO starting on October 1, 2011.

The dual eligibles' enrollment in a Medicaid HMO will not have any effect on the Medicare payment that the providers receive. There is no change in the Medicare billing process. Medicare providers will still bill Medicare (which is the primary payer), as they have done in the past, and they will receive the same Medicare payment that they have been receiving.

When dual eligibles come to the office of a Medicare provider, they will show their Medicare card (as they have done in the past) as well as their new Medicaid HMO card. Whether or not the Medicare provider is in the Medicaid HMO's network, the HMO will automatically pay a portion of the co-insurance up to the Medicaid maximum payment, in accordance with the same Medicaid payment policy that was previously in effect. The Medicare provider does not send a bill to the Medicaid HMO in order for this payment to occur.

We strive to keep an updated mailing list for our publications. If your address has changed or will be changing, or if you are receiving this publication in error, please forward an email update to Helen Rivera at **hrivera@arcnj.org**, or call Helen at **732-246-2525, x35**. ***Thank you!***