The Arc of New Jersey

Mainstreaming Medical Care Program
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Advocating for quality health care for people with intellectual and developmental disabilities

Update from The Arc of New Jersey on the proposed Medicaid managed care changes

Revised, June 1, 2011

We will continue to provide updates as new information becomes available from the state Medicaid office.

1. Mandatory enrollment in a Medicaid HMO; Phase-in process and Letters from Medicaid
   Medicaid staff have announced that they are going to *phase in* the mandatory HMO enrollment of Medicaid beneficiaries who are currently in the fee-for-service system. These are the current plans:

   - Phase 1 group: The Phase 1 group of mandatory enrollees will be DYFS children and the ABD (aged, blind and disabled) individuals who do not have Medicare and are not in a Medicaid waiver. However, people with developmental disabilities, who are Medicaid-only, and who have the Community Care Waiver (CCW) will be enrolled as part of the Phase 1 group.

   - NEW INFORMATION ON THE PHASE 1 ENROLLMENT DEADLINE, AS OF 5/31/11:
     NJ Medicaid is allowing persons who are required to enroll in a Medicaid HMO in Phase 1 -- but who have not already selected a Medicaid HMO -- an additional month to make their HMO selection. Previously, the deadline for making this selection was June 10, 2011. The updated deadline is July 18, 2011. Anyone who is required to enroll in a Medicaid HMO in Phase 1, but does not do so by July 18th, will be auto-assigned for an August 1, 2011 start date. Anyone who has already sent in the enrollment form to join a Medicaid HMO will start their enrollment on July 1st.

     See below for the wording of NJ Medicaid's frequently asked question (FAQ) #2, which explains why the deadline for choosing a Medicaid HMO has been adjusted.

     "What is the deadline for selecting and joining an HMO?

     July 1, 2011 Group
     If you are in the group with a July 1, 2011 effective date you should have received a letter informing you to select an HMO by June 10, 2011 with a July 1, 2011 HMO enrollment date. However, due to a data match error, the "Ready to Enroll" letter contained a July 18, 2011 deadline for enrollment.

     This information systems glitch has created understandable confusion, but Medicaid is encouraging clients to expedite their HMO enrollment as close to the June 10 deadline, as possible. Enrollments received after June 10 or before July 18 will be honored beginning August 1. Non-selection of an HMO by July 18, 2011 will trigger an auto-selected HMO, with coverage beginning August 1.

     *If you were previously excluded from managed care, are dually eligible or participating in a waiver program (other than the Community Care Waiver – CCW), you will receive information regarding the scheduled Fall enrollment.

     You can also learn more about New Jersey's Medicaid Health Plans at www.njfamilycare.org."

   - Phase 2 group: The Phase 2 group of mandatory enrollees will be the dual eligibles (people who receive both Medicaid and Medicare) and Medicaid-only beneficiaries who have a Medicaid waiver. However the Medicaid-only people who have the Community Care Waiver (CCW) are in the Phase 1 group (see above).

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Medicaid beneficiaries who have Medicaid waivers *other than the CCW* will be enrolling 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 Phase 2 group will not be required to enroll in a Medicaid HMO until after the Phase 1 enrollment, but the exact date has not been announced.

2. These services will continue to be covered by Medicaid, but coverage will be via the Medicaid HMO.

- These services were previously "carved out" (i.e., covered by Medicaid fee-for-service) for the ABD population, but were "carved in" for the rest of the Medicaid HMO enrollees. Starting on July 1, 2011 these services will be "carved in" to the Medicaid HMO system for all HMO enrollees:

  - The Pharmacy benefit
  - Home health care

- These services were previously "carved out" of the Medicaid HMO system. Starting on July 1, 2011 these services will be "carved in" to the Medicaid HMO system for all HMO enrollees:

  - 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

3. Exemptions

In the past, Medicaid had an HMO exemption policy for people with disabilities whose health care needs were being met in the Medicaid fee-for-service system. However, the current Medicaid plan is that there will not be any exemptions for anyone. *The Medicaid-only people with disabilities who previously had an exemption will be enrolling in Phase 1.*

4. Switching from one Medicaid HMO to another

Anyone who has not selected a Medicaid HMO by the deadline date will be automatically enrolled, i.e., randomly assigned to an HMO. Individuals will then have 90 days after the auto-enrollment date to change to a different HMO. After that 90-day period, the individual will be required to remain in the HMO until the Open Enrollment period, which will take place annually from October 1 to November 15; anyone requesting an HMO change will be enrolled in the new HMO on January 1. *At any time, Medicaid HMO enrollees will be able to change to another HMO for "good cause" (but this term has not been fully defined).*

5. 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. If a Medicaid HMO enrollee is not sure how to contact a care manager, he/she should be able to do so by calling the toll-free member services number printed on the HMO's ID card, and asking to be connected to a care manager. If you have any difficulty reaching a care manager, please let me know.

Newly enrolled individuals with developmental disabilities should be contacted by a care manager who will do a Complex Needs Assessment. Care managers may be able to facilitate standing referrals for visits to specialists (HMOs require that the patient have a referral from the primary care provider when seeing a specialist.)

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.

6. 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. If any problems arise in this process, please let me know.

7. Mental health services

Mental health services for individuals who are registered with DDD are carved-in to the Medicaid HMO system; mental health services for non-DDD individuals are carved-out. This is the same as the previous Medicaid policy.

8. People with developmental disabilities who have both private health insurance and Medicaid

Most people with developmental disabilities who have private health insurance and Medicaid have used Medicaid *fee-for-service* (also called regular Medicaid) as the secondary payer. However, per the new Medicaid policy, these individuals will need to 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.
- *The network of the private health insurer will prevail, and the Medicaid HMO will cover the copays – even if the provider is not in the Medicaid HMO's network.* This pertains to the primary network for physicians, dentists, mental health providers, hospitals, durable medical equipment, etc.
- However, 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 will cover the copay – regardless of the amount of the copay -- even when the medication is not on the Medicaid HMO's formulary.

If you experience any problems with this, please let me know.

9. <u>The pharmacy benefit is carved-in to the Medicaid HMO system for all Medicaid-only enrollees, starting July 1, 2011</u>

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

The carve-in of the pharmacy benefit will impact *everyone* in the ABD (aged, blind and disabled) group who is Medicaid-only (i.e., not a dual eligible) and is enrolled in a Medicaid HMO – both the previous HMO enrollees and the new ones.

This is what to expect:

- Every Medicaid HMO has a formulary of medications that it will cover. However, Medicaid staff members 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. There will be a "look-back window", in which no medication changes will take place. (The "look-back window" time frame was not specified.)*
- The Medicaid HMOs are going to do outreach to the pharmacies that do special packaging (unit dose, blister packs, etc.) for a large number of our Medicaid-only consumers who live in community residences, to discuss the pharmacies joining the HMO's network. I have heard from many of The Arc's county chapters that it is essential that our consumers are able to continue receiving these specially packaged medications, and I will update you as additional information becomes available.
- There is a process for prior authorization and an exception process.
- In almost all cases, psychotropic medications, when prescribed by mental health professionals (*not* primary care providers) will be covered as prescribed for mental health disorders.

As more information is available, we will share it.

10. Dual eligibles (people with Medicare and Medicaid) will be required to enroll in a Medicaid HMO, in Phase 2 (the mandatory enrollment date not yet announced)

    This is the pertinent information:
    - 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 provider, hospitals, durable medical equipment, etc.
    - However, if there is a service that Medicare does not cover (e.g., ***dental care***), then the network of the Medicaid HMO must be used.
    - Prescription medication will continue to be covered through Medicare Part D

11. Phone numbers for the Medicaid HMOs

    Member Services personnel at each HMO will refer members to a care manager, if appropriate. The HMOs are training the Member Services and Care Management staff about the upcoming changes. The HMO Member Services representatives are available to answer questions of new enrollees and potential enrollees, and if necessary, they will transfer the caller to a care manager to assist with special needs. The Member Services telephone numbers at each HMO are:

Amerigroup	1-800-600-4441	TTY 1-800-855-2880
Healthfirst NJ	1-888-464-4365	TTY 1-800-852-7897
Horizon NJ Health	1-877-765-4325	TTY 1-800-654-5505
United Healthcare Community Plan	1-800-941-4647	TTY 711

    Note: The United Healthcare Community Plan was previously called AmeriChoice

    The Medicaid HMOs and the counties they serve

    Amerigroup: Serving all counties except Salem
    Healthfirst NJ: Serving these 10 counties: Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union
    Horizon NJ Health: Serving all counties
    United Healthcare Community Plan: Serving all counties

12. NJ Medicaid HMO Process for Referral to Specialists

    The attached page, prepared by NJ Medicaid, provides information on each Medicaid HMO's referral process when its members need to see specialists.

13. Frequently Asked Questions (FAQs) developed by the State Medicaid office

    NJ Medicaid developed a set of frequently asked questions (FAQs), which has been posted on the Division of Medical Assistance and Health Services website at: http://www.state.nj.us/humanservices/dmahs/home/index.html. The FAQs explain many aspects of the Medicaid managed care changes and are linked to The Arc of NJ's website.

    Revised: June 1, 2011

New Jersey Medicaid HMO Process for Referral to Specialists

HMO	Referral Process	Paper Referral Needed?	Referral Requirements Waived for Certain Types of Specialists?
Amerigroup New Jersey, Inc.	Members are required to get a referral from their PCP when they require care from a specialist.	Yes	Yes; emergency care, yearly OB/GYN exams, dental care from a Healthplex provider; family planning, prenatal OB care, vision care from a Block Vision provider and EPSDT services from an Amerigroup participating provider.
Healthfirst NJ	Members have direct access to participating specialists without a formal written referral or authorization; however, members are encouraged to coordinate care with their PCPs.	No	N/A
Horizon NJ Health	PCPs make arrangements for the member to see a participating specialist.	Yes; Paper or script with the specialist's name and phone number	Yes; Routine GYN care, mammograms, family planning, annual eye exams, OB care, dental care, behavioral health for DDD members, services at an FQHC, and emergency room visits.
UnitedHealthcare Community Plan	Formal Referrals are not required when using participating providers although all care should be in coordination with a PCP.	No	N/A