Update on the Medicaid Managed Care Changes

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The good news…

- All of the health care benefits that were covered under the previous Medicaid fee-for-service system will continue to be covered by the HMOs!

Brief Overview of HMO networks

- All HMOs contract with doctors, hospitals, clinics, and other health care providers, including labs and durable medical equipment companies. The providers who have signed a contract with a particular HMO are included in the HMO's "network."

- Each Medicaid HMO has its own network. When the initial continuity of care period ends, the new Medicaid-only enrollees may not be able to access some providers who were previously treating them, if those providers are not in the HMO's network.

Mandatory enrollment into a Medicaid HMO – 2 groups

Phase 1 group:

- Enrollment started either July 1 or Aug. 1, 2011
- Enrollees were DYFS children and the ABD (aged, blind and disabled) individuals who do not have Medicare.

Phase 2 Group

- Phase 2: Dual eligibles (people who receive both Medicaid and Medicare) and Medicaid-only beneficiaries who have a Medicaid waiver (excluding the Community Care Waiver).

- People with these Medicaid waivers enroll in Phase 2:
  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)

- Deadline to choose an HMO is Sept. 15, 2011. If HMO is not selected by that date, NJ Medicaid will randomly assign. HMO enrollment is effective on Oct. 1, 2011.

Enrolling in a Medicaid HMO

- To find out which HMOs the consumer's doctors, dentist, hospital, DME provider, etc. are in, you can call the individual office.
- The Health Benefits Coordinator (HBC) processes all Medicaid HMO enrollments. This can be done by mail or over the phone – 1-866-472-5338.
  - Some evening hours: Mon. and Thurs. 8 am to 8 pm. Other days, 8 am to 5 pm.

“Carve-in” vs. “Carve-out”

- When a health service is covered by the Medicaid HMO, that is called a “carve-in.”
- When a health service is covered by the regular Medicaid (fee-for-service) program, that is called a “carve-out.”

Health Services to be “Carved-in” to the Medicaid HMOs

Starting on July 1, 2011, these services were “carved-in” for people with disabilities who are enrolled in a Medicaid HMO.

- 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

No Exemptions

- In the past, Medicaid had an HMO exemption policy for people with disabilities whose health care needs were being met in the regular Medicaid system.
- *Currently: No Medicaid HMO exemptions for anyone*.

Switching From One Medicaid HMO to Another

- After the HMO enrollment starting date, individuals will have 90 days to change to a different HMO, if they want to switch.
- After the initial 90-day period, must remain in the HMO until the Open Enrollment period -- annually from October 1 to November 15. Medicaid HMO changes will be effective each year on January 1.
- To switch to another Medicaid HMO, call 1-800-701-0710.
- *Important: At any time, Medicaid HMO enrollees with disabilities will be able to switch to another HMO for "good cause".*

Care Management Services

- Care management services, usually provided by nurses, are available at all of the Medicaid HMOs. Care management is NOT the same as member services!
- After enrolling in the Medicaid HMO, every new member who receives services from DDD or DYFS should automatically be assigned to an HMO care manager.
  - No need to wait for the letter to contact a care manager. You can reach out to request assistance.
- Individuals with complex medical conditions who are not served by DDD or DYFS will be offered participation in the care management program and assigned an HMO care manager.

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
- United Healthcare Community Plan
  - Toll-free: 1-877-704-8871, ext. 5260

Care Management Services

- Newly enrolled individuals with developmental disabilities should be contacted by a care manager who will do a Complex Needs Assessment.
- Care managers can 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 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.

Continuity of Care Period For New Enrollees

- Newly enrolled HMO members can continue to see current providers initially – even if providers are not in the HMO's network.
- The length of the "continuity of care" period will vary, depending on complexity of the individual's health care problems and availability of in-network health care providers with the expertise to provide the necessary care.
- When the HMO determines that the continuity of care period is ending for a person with a developmental disability, and the enrollee needs to switch to in-network providers, the HMO's care manager should provide assistance in selecting the in-network providers who can meet the person's needs.

Dental Care

- Dental care is a covered service, **including anesthesia,** if medically necessary.
- Most Medicaid HMOs contract with a separate vendor for dental services, which is an additional layer to navigate.
- Contact the HMO's care manager if need help accessing dental services.
- Note: When dual eligibles enroll in a Medicaid HMO, they must use the HMO's network for dental care because Medicare does not cover dental services.

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.
- Partial care and partial hospital services are carved out for all Medicaid beneficiaries.
- This is the same as the previous Medicaid policy.

People Who Have Both Private Health Insurance and Medicaid

- Private health insurance is always the primary payer.
- The network of the private health insurer will prevail. Medicaid HMO should cover the same co-insurance that fee-for-service had covered.
- Can continue to see previous PCP and specialists (per the private health insurance requirements) even if they are not in the Medicaid HMO's network!
- For health services covered by the private health insurance you do not need to switch to the PCP assigned by the Medicaid HMO (the name printed on Medicaid HMO ID card). When specialists are in the private insurance network, can continue to see them without a Medicaid HMO referral.

Private Health Insurance and Medicaid (cont.)

- However, if there is a service that the private health insurer does not cover, then the network of the Medicaid HMO must be used (e.g., personal care assistance, diapers), and you may need a referral from the Medicaid HMO's PCP for those services.

- Hospital procedures: Use hospitals in the private insurance network. If possible, select hospitals that are also in Medicaid HMO network.

- Prescription Medication: The formulary of the private health insurer is primary. Medicaid HMO should cover the co-pay.

Dual Eligibles (Medicaid and Medicare)

Dual eligibles are required to enroll in a Medicaid HMO. Deadline to choose an HMO is Sept. 15, 2011.

- Medicare is always the primary payer, and the Medicaid HMO is secondary.
- Dual eligibles can continue to see any provider who accepts regular Medicare, even if the provider is not in the Medicaid HMO network. Enrollees do NOT need to see a Medicaid HMO PCP to access the Medicare covered services!

Dual Eligibles (Continued)

- If a service is not covered by Medicare (e.g., dental, hearing aids, personal care assistance), then the network of the Medicaid HMO must be used. The enrollee may need a referral from the Medicaid HMO's PCP for the services Medicare does not cover.

- Prescription drugs: No change. Still covered through Medicare Part D.

Medicare Part D co-pays for dual eligibles

- Part D co-pays started July 1, 2011.
- For most dual eligibles with developmental disabilities, drug co-pays are $1.10 for each generic and $3.30 for each brand name drug.
- Benzodiazepines and barbiturates – still covered by NJ Medicaid (not covered by Part D), and no co-pay.
- For dual eligibles on Community Care Waiver (CCW): Starting Jan. 1, 2012, no co-pays for Medicare Part D drugs. (Due to a new regulation at federal level.)

Important Information for Medicare Providers

- 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.

Important Information for Medicare Providers (cont.)

- When dual eligibles come to the office of a Medicare provider, they will show their Medicare card (as they have done in the past) and the new Medicaid HMO card. Whether or not the Medicare provider is in the Medicaid HMO's network, the HMO will 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.

- Medicaid's goal is that the Medicare provider won't need to send a bill to the Medicaid HMO in order for this payment to occur.

People with Medicaid and Medicare and private health insurance

- Must enroll in a Medicaid HMO. Medicaid is the last payer.
- If prescription drugs are covered by private health insurance (not Medicare Part D) then Medicaid HMO will cover drug co-pays.
- Must use Medicaid HMO's network (and the Medicaid HMO's PCP) to access any health services not covered by other insurance, e.g., incontinence supplies, personal care assistance, medical day care, etc.

A guide for people with Medicaid & private insurance and/or Medicare

- NJ Medicaid is developing a free guide booklet for people who have Medicaid plus another health insurance.
- The term Medicaid uses when a consumer has two or more types of insurance is “Third party liability.”
- Guide should be available – Oct. 1, 2011.
- We will post the link on our website: www.mainstreamingmedicalcare.org

Pharmacy Benefit is “Carved-in” to Medicaid HMOs

- The “carve-in” of the pharmacy benefit is impacting *everyone* in the ABD (aged, blind and disabled) group who is Medicaid-only (no other health insurance).
- Dual eligibles will continue to receive their medications from Medicare Part D.
- People with private health insurance and Medicaid should follow the private insurance formulary; Medicaid HMO will cover co-pays.

Pharmacy Benefit – Good news for Medicaid-only persons!

- Anticonvulsant medications: Consumers can stay on the same anticonvulsant(s), even if the drugs are not on HMO's formulary, and even if it is medically necessary to have the brand instead of generic. But if they need to switch to a new anticonvulsant, will need to abide by HMO's formulary.

- Psychotropic meds (for mental health disorders): Medicaid HMOs will cover drugs that enrollees with disabilities were taking before pharmacy benefit carve-in started – even if originally prescribed by primary care physician.

Pharmacy Benefit (cont.)

- In most cases, newly prescribed psychotropic medications, when prescribed by mental health professionals, (not primary care providers) will be covered as prescribed for mental health disorders (even if not on formulary).

- Continuity of care period: 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.

Pharmacy Benefit (cont.)

- Every Medicaid HMO has its own formulary of medications that it will cover. Cost containment processes include step therapy and prior authorization for some drugs.
- This is a quote from Medicaid's frequently asked questions, "Your HMO will make sure your care continues without interruption until they do an assessment of your needs and services. Any changes to your medications will be discussed with you at that time." (Rev. 8-19-11)
- Medicaid HMO should not change medications used by enrollees who have private health insurance.
- HMOs have a process for prior authorization and exceptions, if doctor wants consumer to remain on current medication(s).

Access to Hospitals

- All hospitals accept regular, fee-for-service Medicaid, but all hospitals are not in-network for all Medicaid HMOs!
- Important to ask about the Medicaid HMO affiliations of the hospital(s) the consumer may need for out-patient or in-patient care!
- *In a medical emergency, consumer should go to the closest hospital ER, whether in-network or not!*

Durable Medical Equipment and Supplies (e.g., Diapers)

- New DME and repairs on existing equipment will be covered through the Medicaid HMO.
- Supplies, e.g., diapers, will still be covered, but must be ordered from an in-network company.

The Arc of NJ's form to report problems

- The Arc of NJ has developed a form for reporting problems. The form can be used by persons with developmental disabilities who have a Medicaid HMO problem, or dual eligibles with developmental disabilities having a problem with the Medicare Part D co-pay.

- To date, Medicaid staff have been very responsive to HMO problems The Arc of NJ has brought to their attention.

- A link to the form on our website: www.mainstreamingmedicalcare.org or www.arcnj.org

Appeals Process

- If your HMO denies or limits a particular medical service, you have the right to appeal that decision.
- There are two types of appeals, and you can pursue either or both:
    1. Plan Process Appeal (Stage 1, 2, and 3)
    2. Medicaid Fair Hearing

Appeals Process (Cont.)

- The Plan Process: It starts with a Stage 1 appeal within 60 days of the date of the denial letter. To request a Stage1 appeal, you can call or write to your HMO. If you begin this stage with a phone call, you must follow your phone call with a letter.

- Medicaid 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.

For further details on the appeals process, see our website.

Appeals Process – Continuation of services during the Appeal

- If a consumer was receiving services (e.g., private duty nursing) that the HMO is reducing or terminating, and you want to continue those services 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 that service.

Counties Served by the Medicaid HMOs

- Amerigroup: Serving all counties except Salem
- Healthfirst NJ: Serving the following 10 counties:

Bergen	Essex	Hudson	Mercer	Middlesex
Morris	Passaic	Somerset	Sussex	Union

- Horizon NJ Health: Serving all counties
- United Healthcare Community Plan: Serving all counties

Phone Numbers

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: United Healthcare Community Plan was previously called AmeriChoice

Frequently Asked Questions

Medicaid developed a set of frequently asked questions (FAQs), which is posted on the Division of Medical Assistance and Health Services website at:

http://www.state.nj.us/humanservices/dmahs/home/Medicaid_Client_FAQs.pdf.

The Medicaid FAQs explain many aspects of the Medicaid managed care changes. The most recent revision: Aug. 19, 2011.