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 Medicaid Managed Care Changes

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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: Enrollment was completed on August 1, 2011. The Phase 1 group of mandatory enrollees was DYFS children and the ABD (aged, blind and disabled) individuals who do not have Medicare and are not in a Medicaid waiver. People with developmental disabilities, who have the Community Care Waiver (CCW) without Medicare, were also enrolled as part of the Phase 1 group.

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) were enrolled in the Phase 1 group.**

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)

Phase 2 enrollees should receive a letter in August, informing them that **the deadline to choose a Medicaid HMO is September 15, 2011.** If they do not choose, they will be randomly auto-assigned to a Medicaid HMO.

Please note: NJ's Medicaid HMO system has a "cut-off" date somewhere in the middle of each month. All requests to join a Medicaid HMO that are received *before the cut-off date* are automatically processed for the first of the next month. Therefore, if a caregiver calls or mails in a request for a Medicaid HMO before or during the third week in August (15th thru the 19th), it is very likely that the HMO enrollment would begin on September 1st. If a caregiver wants the Medicaid HMO enrollment to begin on Sept. 1st, then it is advisable to choose quickly. But if the caregiver does not want the HMO enrollment to begin until Oct. 1st, it is advisable to wait until the week of August 22nd or early September (but prior to Sept. 15th) to do the enrollment.

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

"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 adult diapers for consumers who are incontinent) may change, but the services have not been eliminated. These are the health services for people with disabilities that were previously carved out but are now covered by the Medicaid HMOs:

- The Pharmacy benefit
- Home health care
- PT, OT, and speech therapy

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- 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.

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 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 <u>carved out</u> 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 #5 above on care management services.)

8. 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.

9. 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.

10. 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.* 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.
- New Jersey Medicaid is developing a booklet to address the specific concerns of people who have both private health insurance and Medicaid. The booklet should be available in September or October 2011.

11. <u>The pharmacy benefit is carved-in to the Medicaid HMO system for all Medicaid-only enrollees</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.

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.*

<u>Anticonvulsant medications</u>

The Medicaid HMOs will cover **the anticonvulsant drugs that the ABD enrollees were taking before the pharmacy benefit carve-in started, even if the drugs are not on the formulary of the Medicaid HMO. <u>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.</u>**

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.

<u>Medications for mental health disorders</u>

- In almost all cases, psychotropic medications, <u>when prescribed by mental health professionals</u>, (not primary care providers) will be covered by the Medicaid HMOs, for mental health disorders.
- 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.

12. Dual eligibles (people with Medicare and Medicaid) will be required to enroll in a Medicaid HMO, in Phase 2. The deadline to choose a Medicaid HMO is Sept. 15, 2011. (See #1 above).

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

13. 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

14. 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.

15. What are a Medicaid consumer's rights if the HMO terminates, denies, or reduces a particular medical service?

If your Medicaid 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, and the other is 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 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. 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.

Medicaid Fair Hearing: Medicaid/NJ Family Care recipients who are disabled 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 probably 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 you will be contacted again 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.**

16. 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.

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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