

Update on NJ Medicaid Managed Care Changes November 27, 2011

This is an update on the current status of the Medicaid managed care changes. Everyone who receives Medicaid and is living in the community in New Jersey is now enrolled in a Medicaid HMO. The two types of exceptions are: (1) NJ DDD consumers assigned to an out-of-state residential placement and (2) people living in a developmental center, nursing facility, or psychiatric hospital. It is important that you are aware of the following issues:

1. Prescription medication: Medicaid-only consumers are now getting prescription medication from the Medicaid HMO, in accordance with that HMO's formulary. **The Medicaid office has stipulated that Medicaid HMO enrollees with disabilities can continue to receive the same anticonvulsant medications that they were taking prior to the pharmacy benefit carve-in to the Medicaid HMOs – even when consumers were prescribed brand name anticonvulsants. If consumers are having a problem with this, please let the Arc of NJ's Mainstreaming Medical Care (broberts@arcnj.org) and SPAN (familyvoicesnj@aol.com) know.**

2. Documentation of Medicaid HMO problems: On the SPAN website there is a form, developed by the Arc's Mainstreaming Medical Care program, to document significant Medicaid HMO problems. It can be filled in electronically and e-mailed to Bev Roberts (the preferred method) and Lauren Agoratus. We are forwarding these problem forms to Medicaid and tracking them. **If the HMO terminates, denies or reduces a particular health care service, the consumer has the right to appeal that decision.**

3. The Appeals process: **Anyone who has been informed that a medically necessary service was terminated, denied or the number of previously approved hours were reduced (e.g., private duty nursing hours) has the right to file an appeal.** See the attached Healthy Times newsletter (Summer 2011) for further information on the Medicaid HMO appeals process, pp. 4-5. **When filing an appeal you have the right to continue the service that the HMO has terminated or reduced, but this request must be made, in writing, within 10 days of the date of the initial denial letter. To date, the Medicaid HMO denials that we are aware of have been overturned at the Stage 1 (earliest) level, which is very good news!!**

4. One-page flyer, developed by the NJ Dept. of Human Services, to explain that the dual eligibles (people who have both Medicare and Medicaid) can keep their Medicare providers, even when those providers are not in the Medicaid HMO network (attached): This flyer should be widely distributed to families, staff, health care providers and advocates. We hope it will be helpful in preventing the disruption of long-time relationships between Medicare providers and their dually eligible patients.

5. Having Medicaid plus private health insurance and/or Medicare: The Medicaid terminology for having health coverage in addition to Medicaid is "third party liability." To date, there have been some problems for the consumers have both private health insurance (the primary payer) and Medicaid (secondary payer). In an effort to explain the nuances of having Medicaid plus other health coverage, Medicaid has prepared a guide titled: "WHEN YOU HAVE MEDICAID AND OTHER INSURANCE: Balance Billing, Choosing Providers and Other Advice on Third Party Liability (TPL)". See attachments, in English and Spanish.

6. Care Management services: These services, usually provided by nurses, are available at all of the Medicaid HMOs. When done properly, care management is a very helpful service, especially for HMO members with disabilities. Whenever a Medicaid HMO problem arises for a member with a developmental disability, the first outreach should be to a Care Manager to ask for help. You should receive a response within 24 hours, and sooner if the problem is urgent (if leaving a message on voice mail, please indicate if the problem is urgent)! If you know the name and phone number for the consumer's care manager, please call that person. But if you don't know the Care Manager's contact information, please use the phone numbers below to access the correct department within the HMO. *Please note:* Care Management is *not* the same as Member Services.

- **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**

7. Billing issues: Individuals who have Medicaid-only and those who are dually eligible (Medicaid and Medicare) should NOT receive any bills from their Medicaid HMO. Individuals who have private health insurance and Medicaid should not be paying higher co-insurance costs than what they were paying before enrolling in a Medicaid HMO. Note: The dual eligibles do have a Medicare Part D co-pay, which started on July 1, 2011. But those co-pays are relatively small: \$1.10 for each generic drug and \$3.30 for each brand name drug. There should not be any Medicare Part D medication charges higher than the aforementioned costs.