

**FREQUENTLY ASKED QUESTIONS (FAQs)
FOR MEDICAID CLIENTS**

1. What are the changes to the Medicaid program in State Fiscal Year 2012?

Effective **July 1, 2011**, the following individuals previously exempt from managed care enrollment in the Medicaid/NJ FamilyCare must be enrolled in managed care in one of New Jersey's four (4) Medicaid Health Maintenance Organizations (HMOs). This includes:

- individuals in the Community Care Waiver (CCW) program who are **not** dually eligible for Medicare and Medicaid;
- individuals in the Aged, Blind and Disabled (ABD) category who have Medicaid only;
- all DYFS children, except out-of-state placements;
- individuals who have been allowed exemptions from managed care enrollment;
- individuals on Medicaid who are also enrolled in or covered by a private health plan;
- Medicaid individuals who have been in the pharmacy lock-in program; and
- Breast and Cervical Program Medicaid individuals.

*If you are dually eligible or participating in a waiver program (other than the Community Care Waiver – CCW), you will receive information by mail regarding the October 1, 2011 enrollment.

Medicaid is changing from the system you are currently in to a managed care delivery system. Your HMO will be responsible for managing your health care and offering a network of providers from which you can get services.

If you have both Medicare and Medicaid, you can continue to use your Medicare provider network as well as your Plan's Medicaid network (see questions 33-38 below).

2. Who is not in managed care as of August 1, 2011?

Medically Needy - Long Term Care and not Long Term Care
Individuals in ICF/IDs
Individuals in inpatient psychiatric hospitals
Individuals in the PACE program
Individuals in Nursing Facilities - Long Term Care
Individuals in Out of State Placements
Individuals enrolled in the Cystic Fibrosis Program with the Department of Health and Senior Services.

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Note: The Department of Health and Senior Services' Cystic Fibrosis Program is not a Medicaid program.

Fee-for-service Newborns

Note: For Individuals in acute hospitals at the time of enrollment, managed care enrollment begins after discharge.

Presumptively Eligible pregnant women

Presumptively Eligible Children

*Individuals who are dually eligible for Medicaid and Medicare, in a waiver program (except the Community Care Waiver – CCW), or who have otherwise been excluded from managed care will be enrolled in the Medicaid/NJ FamilyCare program on October 1, 2011. CCW clients not currently in managed care will be enrolled in an HMO effective August 1, 2011.

Enrolling in an HMO

3. 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 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, 2011.

*If you are dually eligible or participating in a waiver program (other than the Community Care Waiver – CCW), you will receive information regarding the scheduled October 1, 2011 enrollment.

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

4. What are the 4 HMOs in which I can enroll?

The four (4) plans are:

- a) Amerigroup New Jersey, Inc. (Serving all counties except Salem)
- b) Healthfirst Health Plan of New Jersey (in 10 counties: Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union)
- c) Horizon NJ Health (Serving all counties)
- d) UnitedHealthcare Community Plan (Serving all counties)

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For more information about New Jersey's Medicaid HMOs, visit www.njfamilycare.org.

5. How do I enroll in an HMO?

You will receive a packet of information from the NJ FamilyCare/Medicaid Program entitled "Ready to Enroll."

The packet will have information that will help you select a health plan. Assistance will be available to you from the NJ FamilyCare program and/or from the Medical Assistance Customer Center (MACC).

NJ FamilyCare hours of operation and phone number:

- Monday and Thursday - 8 a.m. to 8 p.m.;
- Tuesday, Wednesday and Friday - 8 a.m. to 5 p.m.
- Phone Number: 1-866-472-5338 (TTY 800-701-0720)

MACC hours of operation and phone number:

- Monday through Friday - 8:30 a.m. to 4:30 p.m.
- Information about the nearest MACC can be obtained from the Medicaid Hotline at 1-800-356-1561.

If you have a Medical Exemption and need additional assistance in choosing your HMO, the MACC Regional Staff Nurses are there to help you.

Once you are enrolled, you will receive information from your HMO about how your Health Plan will work.

6. Do I have to wait for the "Ready to Enroll" packet to select an HMO, or can I do it by phone?

If you are ready to enroll now you do not need to wait for the packet. See number 7 below to call the NJ FamilyCare/Medicaid program to sign up.

7. Can I select an HMO of my choice?

You can select an HMO when you receive your "Ready to Enroll" packet. You can call the NJ FamilyCare/Medicaid program's special enrollment phone number at 1-866-472-5338 (TTY 1-800-701-0720) to make your selection. You can ask the enrollment representative which HMOs your current doctor already participates with when deciding which HMO to join. Hours of operation are Mondays and Thursdays from 8 a.m. to 8 p.m. and Tuesdays, Wednesdays and Fridays from 8 a.m. to 5 p.m.

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You can also learn more about New Jersey's Medicaid health plans at www.njfamilycare.org.

8. What happens if I don't select an HMO?

If you don't select an HMO, one will be selected for you by the NJ FamilyCare/Medicaid program. We will mail you a letter with this information. If you then wish to select a different HMO, you can change to an HMO of your choice in the first ninety (90) days after you are automatically enrolled.

9. What if I want to change my HMO?

You can change your HMO once a year during the Annual Open Enrollment Period from October 1 to November 15. And, you still have the option of changing your HMO for "good cause" at any time by calling NJ FamilyCare/Medicaid at 1-866-472-5338 (TTY 800-701-0720).

10. Will the HMOs create a special unit to handle the transition in October? Is there a special phone number we can call at the HMO if we have problems or questions?

Members can call the Member Services line using the telephone number listed on their Member ID card. Member Services 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, if necessary, transfer you to a care manager to assist you with your 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
UnitedHealthcare	1-800-941-4647	TTY 711

Obtaining Services

11. Can I still choose to get services under Medicaid (fee-for-service/FFS) instead of managed care?

No. Services will be available only through one of New Jersey's 4 Medicaid HMOs to most individuals enrolled in NJ FamilyCare/Medicaid Program.

12. I currently have an approved medical or other exemption from managed care enrollment. Will I have to be enrolled in an HMO?

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Yes, unless you are in one of the groups that will not be required to enroll in Medicaid managed care at this time (see answer to Question #2), you must be enrolled in an HMO for your medical services.

13. What will happen to my services after I enroll in my HMO? Can I keep my current doctors/service providers?

Your HMO will ensure that your care continues after enrollment without interruption. Once you are enrolled, the HMO will do an assessment of your needs and any changes to your care plans or your providers will be discussed with you at that time. In most HMOs, you will need to use providers within the HMO's network. However, your doctors may already be in the network or may enroll as a provider in the HMO's network. If you have primary insurance with a private health plan or Medicare you should follow that health plan's rules for choosing your providers for all covered benefits covered by that health plan. (See questions 33-38 below.)

14. I understand that certain services, which have been available under Medicaid fee-for-service, will now be available to me through my HMO. What are these services?

Starting **July 1, 2011**, the following services will be provided through your NJ FamilyCare/Medicaid managed care HMO:

1. Home Health for all members, including members who have been receiving this benefit with Medicaid fee-for-service;
2. Pharmacy for all Medicaid-only members, including those members who have been receiving this benefit with Medicaid fee-for-service (Those with Medicaid and Medicare will continue to receive pharmacy benefits through their Medicare Part D Drug Plan. Questions 22a., 22b., and 23 below do not apply to those with Medicare and Medicaid.);
3. Personal Care Assistant (PCA) (Personal Preference, a self directed service, will remain under Medicaid fee-for-service); and
4. Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)
5. Adult and Pediatric Medical Day Care Services.

Dually eligible and waiver program clients (except Medicaid-only CCW clients) will continue to receive these services under Medicaid fee-for-service until they enroll in a managed care plan on October 1, 2011.

15. I currently get home health services in FFS. Will I still get home health from the same provider who serves me now?

Your HMO will make sure your care continues after enrollment without interruption, with the same provider. Once you are enrolled, the HMO will do an assessment of your needs and any change to your care plan or providers will be

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discussed with you at that time. In most HMOs you would need to use a provider within the HMO's network. However, your home health provider may already be in the network, or may request to enroll as a provider in the HMO's network.

16. I currently get Personal Care Assistant (PCA) services under fee-for-service Medicaid; will I still get PCA from the same provider who serves me now?

Your HMO will make sure your care continues after enrollment without interruption, with the same provider. Once you are enrolled, the HMO will do an assessment of your needs and any change to your care plans or providers will be discussed with you at that time. In most HMOs you would need to use a provider within the HMO's network. However, your PCA provider may already be in the network, or may request to enroll as a provider in the HMO's network. The Personal Preference Program, a self directed service, will remain Medicaid fee-for-service.

17. I currently get physical therapy, speech therapy and/or occupational therapy under regular Medicaid FFS; will I still get these therapies from the same provider(s) who serve me now?

Your HMO will make sure your care continues after enrollment without interruption, with the same provider with some exceptions. Once you are enrolled, the HMO will do an assessment of your needs and any changes to your care plans will be discussed with you at that time. In most HMOs you would need to use a provider within the HMO's network. However, your therapy provider may already be in the network, or may request to enroll as a provider in the HMO's network.

18. Will Mental Health/Behavioral Health services still be in Medicaid fee-for-service?

Except for DDD clients, mental health/behavioral health services remain in Medicaid Fee-for-Service.

19. Will Family Planning Services be carved in to managed care?

HMO enrollees in Plans A, B, C, and certain Plan D enrollees, may use providers in the HMO network or Medicaid providers outside of the HMO network for family planning services and supplies. If you are in Plan D, call your HMO to ask if you can get these services out-of-network.

20. Are the services by each HMO the same?

The Medicaid benefit package is the same in each HMO.

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21. What if my HMO tells me that I cannot have a particular medical service? What are my rights?

If your HMO denies you a particular medical service, you have the right to appeal that decision. If you want to appeal your HMO's decision to deny a service, you (or your health care provider, with your written consent) can request a Stage 1 appeal within 60 days of the date of the denial letter. (Some HMOs allow up to 90 days to request an appeal. Ask your HMO what their time frame is). To request a Stage 1 appeal, you can call or write to your HMO. You must follow your phone call up 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 denial of the service.

If your HMO reviews your Stage 1 appeal request, and you are not satisfied with that decision, you, or your health care provider, with your written consent, can request a Stage 2 appeal. You must request your Stage 2 appeal within 60 days of the date of the denial letter. (Some HMOs allow up to 90 days to request an appeal. Ask your HMO what their time frame is). Again, you must follow your phone call up with a letter to the HMO.

If you are still not satisfied with the HMO's decision after the Stage 2 appeal, you (or your health care provider, with your written consent) 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.

Furthermore, Medicaid/NJ FamilyCare A and certain NJ FamilyCare D members have the right to request a Medicaid Fair Hearing at any time. If you are not sure if you have the right to a Medicaid Fair Hearing, you can call the HMO's member service telephone number and ask the representative to help you. A written request for a Medicaid Fair Hearing must be made within twenty (20) days of the date of the denial letter.

Prescription Services

22a. What about my prescriptions? Will my current medications be automatically continued? Will my new HMO honor previous Prior Authorizations?

For Medicaid-only members, your HMO will make sure your care continues after enrollment 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.

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22b. Atypical anti-psychotic and anti-convulsant medications - Will I have access to brand name drugs including atypical anti-psychotic and anti-convulsant medications?

New HMO members and current HMO members whose pharmacy benefits were covered by Medicaid fee-for-service can continue taking the atypical anti-psychotic and/or anti-convulsant drugs prescribed at the time of the transition to the HMO for your pharmacy benefit. You can continue taking these prescriptions until such time as your doctor recommends a change in your plan of care.

All other prescriptions - For Medicaid-only members, HMOs can authorize a drug which is not on their approved formulary (list of approved drugs) when requested by the individual's primary care physician (PCP) or other referring provider if they certify to the HMO that the drug is medically necessary. The HMO must provide you with an exception process to obtain the brand name drug if the HMO's formulary only covers the drug's generic equivalent.

When behavioral health medications are prescribed by behavioral health providers these do not require a prior authorization and will generally be covered subject to routine drug utilization review edits for safety (e.g., drug to drug interactions with other medications currently being prescribed). Behavioral health drugs prescribed by non-behavioral health providers, such as pediatricians, are subject to prior authorization and a health plan's formulary.

23. How will I access my pharmacy benefits?

If you are **not** currently enrolled in a NJ FamilyCare/Medicaid HMO, you will be enrolled (see question 3 above). New members enrolling in an HMO will receive pharmacy benefits from their NJ FamilyCare/Medicaid HMO unless they also have Medicare or private insurance. You may use your HMO Member ID card at the pharmacy counter to obtain prescriptions.

If you are currently enrolled in a NJ FamilyCare/Medicaid HMO and are Medicaid-only, beginning **July 1, 2011**, you will receive pharmacy benefits from your HMO or beginning October 1, 2011 for dually eligible and waiver program clients (except Medicaid-only CCW clients). You will no longer receive these benefits through the Medicaid fee for service (FFS) program. If you have private health insurance in addition to Medicaid, see #25 below.

24. Will you require HMOs to cover all or substantially all 6 protected classes of drugs like Medicare Part D does?

Not at this time. The HMO contract provides protections so you can get the drugs you need that are determined by your medical professional to be medically necessary. You have a right to appeal any decision regarding your benefits to the HMO and even to the NJ Department of Banking and Insurance for covered

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services; see #21 above. Services are continued during the course of an appeal until a final decision is reached if you request a continuation of benefits in writing.

The DMAHS Office of Managed Health Care reviews each HMO's formulary (list of approved drugs) and the DMAHS Office of Quality Assurance monitors complaints and grievances related to all aspects of the managed care contract, including pharmacy. DMAHS will monitor this policy and revisit it if circumstances merit.

25. I have private health insurance in addition to Medicaid. How will my pharmacy benefits be covered?

Your private health insurance is your primary coverage for pharmacy benefits if that health plan has pharmacy coverage. Your providers should refer to the private health plan's drug formulary (list of approved drugs) when writing your prescriptions. Your NJ FamilyCare/Medicaid HMO will cover any balance and/or co-pay not covered by the private health insurance plan provided the prescription was approved for coverage by the private health plan.

26. Will my Medicare Part D co-payments still be covered by the State of NJ for pharmacy services?

No.

27. Is there a maximum monthly co-pay for Medicare Part D drugs?

No. However, all those with Medicare and Medicaid automatically receive federal assistance with drug costs under the Medicare Part D Low Income Subsidy Program (LIS). LIS has maximum co-pays for Part D covered drugs of \$1.10 for each generic drug and \$3.30 for each brand name drug for most clients. Once members with high drug costs receive medications worth \$6,447.50 in 2011, the LIS covers 100% of Part D co-pays.

28. How much are the co-payments?

Most Medicaid clients who are dually eligible for Medicare and Medicaid benefits will have a \$1.10 co-payment for generic drugs and a \$3.30 co-payment for brand drugs. This applies to people who qualify for Medicare's low income subsidy (LIS) level 1.

Some dually eligible Medicaid clients will have a \$2.50 co-payment for generic drugs and a \$6.30 co-payment for brand drugs (Medicare's low income subsidy (LIS) level 2).

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There is no co-payment for dually eligible Medicaid clients under low income subsidy (LIS) level 3.

29. What happens if I can't afford the co-pays?

No extra help will be provided by Medicaid to help cover the cost of your medication. If you are currently taking a brand name medication where a generic is available, you should speak with your doctor to switch you to a generic drug to help lower the cost of your medication.

30. What medications will the NJ FamilyCare/Medicaid program cover that the Medicare Part D prescription drug plan does not cover?

When dually eligible clients enroll in a NJ FamilyCare/Medicaid HMO, the State of New Jersey will only cover the following medications for beneficiaries enrolled in a Medicare Part D prescription drug plan: benzodiazepines, barbiturates, over-the-counter smoking cessation products, and prescription vitamins, (other than pre-natal and fluoride vitamin preparations).

Care Management and Care Coordination

31. Does everyone in managed care get a care manager?

Individuals with special needs will be assessed for care management when they are enrolled in their HMO. All members who have complex medical conditions will be offered participation in the Care Management Program and assigned a care manager upon enrollment. DDD and DYFS members are automatically assigned care management when they enroll. The HMO care management departments are available to assist you with care arrangements during this transition. Call the Member Services number on your member ID card and ask to speak with a care manager if you need assistance with services you are currently receiving during the transition.

32. I am in the Global Options (GO) Waiver. Which services will be provided by the HMO and which will be provided under the GO Waiver? How will my services be coordinated?

GO medical services will be covered by your HMO, except behavioral health services which remain covered by Medicaid FFS. Clients of DDD behavioral health services are covered by the HMO.

Waiver services which remain covered by Medicaid FFS include:

- Adult family care;
- Assisted living;
- Attendant care;
- Caregiver/participant training;

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- Care management;
- Chore services;
- Community transition services;
- Environmental accessibility adaptations;
- Home based supportive care;
- Home-delivered meal service;
- Personal emergency response systems;
- Respite care;
- Special medical equipment and supplies;
- Social adult day care;
- Transitional care management;
- Transportation to waiver and non-state plan covered services.

There are a few exceptions:

1. If person enters a nursing facility, GO eligibility ends;
2. If person is DDD eligible, behavioral health services are contained in the HMO benefit package;
3. A person can choose personal care assistant services through the HMO or home based supportive care through the waiver, but not both.

Your HMO care manager and GO waiver case manager will communicate with each other to coordinate the medical and waiver services you need.

When you Have Both Medicaid and Private Health Insurance (TPL) or Medicare

- 33. Does a private health insurance doctor have to be enrolled in Medicaid as part of the network in order to serve a Medicaid client who is in managed care?**

If the Medicaid client also has private health insurance, the answer is no. If the Medicaid client does not have private health insurance, the answer is yes. However, services not covered by the private health insurance plan that *are* covered by Medicaid must be obtained from a Medicaid HMO provider.

- 34. Does a Medicare doctor have to be enrolled in Medicaid as part of the network in order to serve a Medicaid client who is in managed care?**

If the Medicaid client is also in Medicare, the answer is no. If the Medicaid client is not in Medicare, the answer is yes. However, dental and other non-Medicare covered services must be obtained from the Medicaid HMO providers.

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35. Can I continue using the primary care provider (PCP) under my private health insurance program or do I need to change to a PCP with my Medicaid HMO?

You should continue using the PCP with your private health insurance program since that is your primary insurance. The Medicaid HMO will still need to assign one of their network PCPs to you in case you need services that are **not** covered by your private health insurance and **are** covered by your Medicaid HMO. The Medicaid HMO PCP's name will appear on your Medicaid HMO member ID card for your reference, should you need it.

36. Can the Medicare doctor balance bill a dual eligible (Medicare and Medicaid client)?

No. The Medicare provider is required by law to accept the payment from Medicare and Medicaid as payment in full if they agree to treat a patient for covered benefits who has both Medicare and Medicaid.

37. Can a Medicare doctor refuse to see a client if that client has both Medicare and Medicaid, or has Medicaid only?

Yes.

38. When should a client, who has both Medicare and Medicaid coverage, use the Medicare ID card or the Medicaid HMO member ID card?

Whenever a client has a medical visit or has a prescription filled at the pharmacy, he/she should present **both** Medicare and Medicaid HMO member ID cards so the provider has all of the insurance information on record to submit claims for payment.

39. Will existing providers be automatically enrolled as an HMO network provider?

No; however, during the continuity of care period, services and providers will continue until the HMO conducts an assessment of the member. A new care plan may be put in place at that time and the member may need to select a provider from the HMO's network.

40. Will referrals be required for specialists?

Generally, yes. Medicaid-only members will need to follow HMO policies regarding referrals to receive care from specialists. Check with your HMO to find out how their referral process works. If you have private health insurance or Medicare, you should follow those coverage policies regarding referrals to specialists for services those programs will cover.

Transportation

41. How will transportation be affected?

Medicaid clients can arrange for transportation services through the State's transportation broker, LogistiCare, by calling 1-866-527-9933 (TTY 1-866-288-3133) at least two business days before the scheduled appointment. The HMO will only cover ground transportation services in the event of an emergency (this means emergency ambulance services to an emergency room, and if necessary, the transfer to another hospital if the patient was not admitted to the first hospital). Exception: Adult Day Health Care and Pediatric Medical Day Care transportation services are included into the per diem payment to these providers and arranged through the provider.