FREQUENTLY ASKED QUESTIONS (FAQs)
FOR MEDICAID CLIENTS

1. What changes are proposed for the Medicaid Program in the State Fiscal Year 2012 budget?

Effective July 1, upon the adoption of the State Fiscal Year 2012 budget, individuals who were 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). Also, individuals who are dually eligible for Medicaid and Medicare, in a waiver program, or who have otherwise been excluded from managed care will be enrolled in the Medicaid/NJ FamilyCare program in the fall.

Medicaid is changing from the system you are currently in to Managed Care Medicaid. 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 30-32 below).

2. How will I know if these changes are approved in the State 2012 Budget?

You will be notified separately by letter if there will be any changes to the proposed state 2012 budget.

3. Who is not in Managed Care as of July 1, 2012 when the SFY 2012 budget is approved?

Medicaly 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 with Cystic Fibrosis
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

Also, individuals who are dually eligible for Medicaid and Medicare, in a waiver program, or who have otherwise been excluded from managed care will be enrolled in the Medicaid/NJ FamilyCare program in the fall.
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)

For more information about New Jersey’s Medicaid HMOs, visit [www.njfamilycare.org](http://www.njfamilycare.org).

5. **How do I enroll in an HMO?**

You, 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 at 1-866-472-5338 (TTY 800-701-0720) and/or from the Medical Assistance Customer Center. Hours of operation are Monday through Friday from 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. **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 special enrollment phone number at 1-866-472-5338 (TTY 800-701-0720) and 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.

You can also learn more about New Jersey’s Medicaid Health Plans at [www.njfamilycare.org](http://www.njfamilycare.org).

7. **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.
8. **What if I want to change my HMO?**

   You can change your HMO once a year during the 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).

9. **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.

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

    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 #3), you must be enrolled in an HMO for your medical services.

11. **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 a provider within the HMO’s network. However, your doctor may already be in the network or may enroll as a provider in the HMO’s network.

12. **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 13a., 13b., and 14 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)
    4. Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)
    5. Adult and Pediatric Medical Day Care Services

Dually eligible and waiver program clients will continue to receive these services under Medicaid Fee-for-Service until they enroll in a managed care plan later this fall.
13a. 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 ensure that 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.

13b. Will I have access to brand name drugs including atypical anti psychotic medications?

For Medicaid-only members, HMO’s can authorize a drug which is not on their approved formulary (list of approved drugs) when requested by the individual’s Primary Care Physician 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.

14. How will I access my pharmacy benefits?

If you are not currently enrolled in a NJ FamilyCare/Medicaid HMO, you will be enrolled beginning July 1, 2011 or later this fall for dually eligible and waiver program clients. New members enrolling in an HMO will also receive pharmacy benefits from their NJ FamilyCare/Medicaid HMO unless they also have Medicare. 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 later this fall for dually eligible and waiver program clients. You will no longer receive these benefits through the Medicaid Fee for Service (FFS) program.

15. Will my Medicare Part D copayments still be covered by the State of NJ for pharmacy services?

No. Your Medicare Part D co-payments will no longer be covered for pharmacy services processed on or after July 1, 2011, except for individuals who are dually eligible for Medicare and Medicaid and are in a home and community based waiver program.

16. How much are the copayments?

For full benefit duals with low income subsidy level 1 generics $2.50 and brands $6.30. For full benefit duals with low income subsidy level 2 generics $1.10 and brands $3.30. For full benefit duals with low income subsidy level 3 there is no copayment.

17. What happens if I can’t afford the copays?

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 to help lower the cost of your medication.
18. **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 NJ 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).

19. **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 services. Services are continued during the course of an appeal until a final decision is reached.

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. We will monitor this policy and revisit it if circumstances merit.

20. **Is there a maximum monthly co-pay for Medicare Part D drug?**

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 copays for Part D covered drugs of $1.10 for each generic drug and $3.30 for each brand name drug. Once members with high drug costs receive medications worth $6,447.50 in 2011, the LIS covers 100% of Part D copays.

21. **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.
22. 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 ensure that 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 discussed with you at that time. In most HMO’s 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.

23. 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 ensure that 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.

24. 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 ensure that 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 HMO’s 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.

25. I am in the Global Options Waiver. Which services will be paid for by the HMO and which will be provider under the GO Waiver? How will my services be coordinated?

Medical services will be covered by your HMO as a State Plan Service, except behavioral health services which remain covered by Medicaid FFS.

Waiver services which remain covered by Medicaid FFS include: Adult family care; assisted living; attendant care; caregiver/participant training; 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 services.

There are a few exceptions: 1. If person enters nursing facility, GO eligibility ceases; 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.

26. **Will the HMOs create a dedicated unit to handle the transition in July? Is there a dedicated 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 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

27. **Will Mental Health/Behavioral Health services still be in Medicaid Fee-for-Service?**

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

28. **Will Family Planning Services be carved in to Managed Care?**

HMO enrollees in Plan A, B and C may use providers in the HMO network or Medicaid providers outside of the HMO network for family planning services and supplies.

29. **Are the services by each HMO the same?**

The Medicaid benefit package is the same in each HMO.

30. **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.

31. **Can the Medicare doctor balance bill a dual eligible (Medicare/Medicaid)?**

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

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

Yes
33. **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.

34. **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.

35. **How will transportation be affected?**

Medicaid clients can arrange for transportation services through the transportation broker, LogistiCare. The HMO will only cover transportation services in the event of an emergency (this covers 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 and Pediatric Medical Day Care transportation services are included into the per diem payment to these providers and arranged through the provider.

36. **Will referrals be required for specialists?**

Yes, Medicaid-only members will need to follow HMO policies regarding referrals to receive care from specialists.