FREQUENTLY ASKED QUESTIONS (FAQS)
FOR PROVIDER INDUSTRY

1. What changes are proposed for the Medicaid Program in the State Fiscal Year 2012 budget? Will clients be notified if these changes are not approved in the 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 program 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. Also, individuals who are dually eligible for Medicaid and Medicare, in a waiver program (except for Medicaid-only CCW clients), or who have otherwise been excluded from managed care will be enrolled in the Medicaid/NJ FamilyCare program **in the fall**.

For most clients, Medicaid is changing from Medicaid Fee-for-Service (FFS) to Medicaid Managed Care. Clients currently in a program operated under Medicaid FFS must enroll in an HMO unless they are in an excluded group.

Care will now be coordinated by the member's HMO and for the most part, individuals will need to use providers that are in the health Plan's network. The State's HMO contract requires continuity of care with existing services and providers until the HMO can assess the member and put any alternate plans of care in place.

Clients who have Medicare coverage can use Medicare providers as well as the HMOs Medicaid provider network. However, dental and other non-Medicare covered services must be obtained from the Medicaid HMO providers.

Clients will be notified if there are changes to the proposed State 2012 budget.

2. 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 has 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.

*If you were previously excluded from managed care, are dually eligible or participating in a waiver program (other than the Community Care Waiver – CCW), you will receive information regarding the scheduled Fall enrollment.

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

3. Why is this budget initiative necessary?

A significant percentage of New Jersey's Medicaid clients are successfully enrolled in managed care. The 2012 budget initiative to enroll additional populations and carve in additional services to managed care will make it possible to better manage and coordinate client care and avoid the reductions in services that other states are experiencing this year.

4. Does the Budget Initiative affect clients with both Medicare and Medicaid?

Yes, the initiative requires the enrollment in managed care of those with dual eligibility in Medicare and Medicaid. If clients have both Medicare and Medicaid, they can continue to use the Medicare network except for dental services which Medicare doesn't cover, as well as their HMO's Medicaid network for Medicaid services. Clients who are dually eligible for Medicaid and Medicare services, and clients participating in a waiver program (except Medicaid-only CCW clients) will need to enroll in a managed care plan in the fall.

5. What excluded groups will remain Medicaid Fee-for-Service?

- 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 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

6. What services will now be carved in to Managed Care?

On July 1, 2011, the following services will be covered by the NJ FamilyCare/Medicaid HMOs:

1. Home Health for all members, including members who have been receiving this benefit with Medicaid Fee-for-Service
2. Pharmacy for all members, including those members who have been receiving this benefit with Medicaid Fee-for-Service
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.

7. What are the 4 New Jersey HMOs?

The four (4) plans are:

1. Amerigroup New Jersey, Inc. (Serving all counties except Salem)

2. Healthfirst Health Plan of New Jersey (in 10 counties: Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union)

3. Horizon NJ Health (Serving all counties)

4. UnitedHealthcare Community Plan (Serving all counties)

8. What will happen to Pharmacy benefits?

All clients who are currently enrolled in a NJ FamilyCare/Medicaid managed care HMO beginning July 1, 2011, will receive pharmacy benefits from their health plan. They will no longer receive these benefits through the Medicaid Fee-for-Service program.

Clients who are not currently enrolled in a NJ FamilyCare/Medicaid managed care HMO, but who will be enrolled over the next few months will also receive pharmacy benefits from their NJ FamilyCare/Medicaid managed health care plan.

Clients may use their HMO Member ID card at the pharmacy counter to obtain prescriptions.

9. How will prescriptions and renewals be handled during this transition?

The client's HMO will assure that care including pharmacy continues after enrollment without interruption until an assessment is done of the individual's needs and services. Notices will be sent to affected members and prescribers about changes, which will include information about the medical exception process to assure continuity of care.

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 or other referring provider if they certify medical necessity for the drug to the HMO. If the HMO's formulary includes generic drug equivalents in their formulary, the Plan will provide for a brand name exception process when medically necessary.

10. What will happen to existing prior authorizations? Will they be honored?

Prior authorizations will be honored until a reassessment can be done by the HMO. Prior authorizations may be changed at that time.

11. If I am a Medicaid provider, am I automatically an HMO provider?

You can continue to be a provider for continuity of care purposes until the member is assessed by the HMO and a new care plan put in place. The HMO may require that the member choose a provider from within their own network. To be a managed care provider, you will need to contact the HMO and apply to be considered as a participating provider in their network. Each HMO has its own process for recruiting and maintaining its provider network. Provider relations at each HMO are:

- Amerigroup New Jersey, Inc. 1-800-454-3730
- HealthFirst NJ 1-866-889-2523
- Horizon NJ Health 1-800-682-9091
- UnitedHealthcare Community Plan 973-297-5635

12. Will my clients have to change providers when they join an HMO if I'm not an HMO provider?

No. The HMOs must maintain continuity of care for new enrollees until an assessment of the member's needs is done. A new care plan may be developed at that time. The continuity of care period is provided to make the transition as seamless as possible to members and to avoid disruptions in their care.

13. How will claims be processed after July 1, and after the dually eligibile and waiver program clients' HMO enrollment goes into effect later this fall? How will claims incurred before the HMO enrollments take effect be paid?

Effective July 1, 2011, and again in the fall (date TBD), claims must be submitted to the HMO for newly enrolled HMO members.

Claims incurred prior to these effective dates, will be handled by the state's fiscal agent.

14. Will my clients continue to receive the same services they are receiving now?

Your HMO will assure that the members care continues after enrollment without interruption. Once enrolled, the HMO will do an assessment of the member's needs and a new care plan may be put in place at that time.

15. Will rates remain the same as in Medicaid Fee-for-Service? Can the HMO pay different rates and when will this take effect?

Each HMO sets their own fee structure for the providers with whom they have a contract or agreement.

16. Will the HMOs accept new provider enrollments?

This is a decision that each HMO will make. Continuity of care provisions will be in place during this transition to avoid disruption of care. This includes maintaining current client/provider relationships until a new assessment of the member can be done and a new care plan put in place. Most HMOs have requirements for selection of providers and the member is assisted to make these choices.

17. How will Medicare services be impacted if Medicare is primary?

These changes should not have any impact on Medicare services. Clients with Medicare can continue to use their Medicare network providers, and will have access to their HMO's Medicaid network as well.

18. Will individuals served continue to receive their home and community based waiver services separate from the HMO?

As a rule, the HMOs will provide medical services and the Waiver programs will provide all other services available under the respective waiver. A set of summary charts that explain this further are attached to the FAQs.

19. Will existing DHSS and DDS waiver case managers be informed of these changes?

Yes. Communications are underway to prepare case managers for the transition.

20. How will the co-pay for adult medical day care services be handled after HMO enrollment?

Adults will have a $3.00 co-pay for medical day care per visit, not to exceed $25.00 per month maximum.

21. Will Mental Health/Behavioral Health services be carved into managed care?

No. Except for DDD, mental health/behavioral health services remain in Medicaid Fee-for-Service.

22. How will Durable Medical Equipment (DME) rental to purchase agreements be handled?

The HMO will make arrangements with non-participating DME providers for the remaining months of the rental at the non-participating reimbursement rate, and with participating DME providers at the contracted rate. Since each HMO has its own policies on which items are on their DME rental to purchase list, you should contact the HMOs' provider relations departments to find out which items are on their list.

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HealthFirst NJ	1-866-889-2523
Horizon NJ Health	1-800-682-9091
UnitedHealthcare Community Plan	973-297-5635

23. How will crossover claims be handled?

New Jersey's fiscal agent will provide each HMO with electronic crossover claim submissions to facilitate timely claims payment.

24. I am a PCA provider; will I be required to be Medicare Certified?

In New Jersey, PCA providers are not required to be Medicare Certified since PCA is not a Medicare covered service. Hospice providers must be Medicare certified and only Medicare certified and DHS licensed home health agencies (specialty 380) can provide skilled nursing visits. All other home care agencies are required to have a Consumer Affairs license and also be accredited by one of the accrediting bodies for PCA services. These are:

- Community Health Accreditation Program, Inc. (CHAP)
- Commission on Accreditation for Home Care, Inc. (CAHC)
- The Joint Commission (TJC)
- National Association for Home Care/HomeCare University (NAHC)

25. I am currently a provider under Medicaid Fee-for-Services (for example, Adult or Pediatric Medical Day Care, Pharmacy, Home Health, Therapy). If I contract with an HMO, what will I be paid? If I want to contract with an HMO, who do I call?

Each HMO sets its own fee structure and rates in its contracts and agreements with vendors/providers. You can contact the HMOs' provider relations departments to find out how to apply to become a participating provider:

Amerigroup New Jersey, Inc.	1-800-454-3730
HealthFirst NJ	1-866-889-2523
Horizon NJ Health	1-800-682-9091
UnitedHealthcare Community Plan	973-297-5635

26. 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.