



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

Volume 10 No. 73

October 2000

TO: All Providers
SUBJECT: NJ FamilyCare
EFFECTIVE: Immediately

PURPOSE: The purpose of this newsletter is to inform all providers of the implementation of the NJ FamilyCare program. N.J.S.A. 30:4J-1 et seq., the Family Care Health Coverage Act, created the NJFamilyCare program within the Division of Medical Assistance and Health Services.

BACKGROUND: The NJ FamilyCare program was created to meet the needs of adults and children who were previously unable to obtain affordable health coverage. This group includes parents, caretakers, single adults, and couples without dependent children who meet the income requirements, and those who were ineligible for Medicaid/NJ KidCare because of their immigrant status. Rules governing the NJ FamilyCare program were effective September 1, 2000. The new rules will allow the Division to administer new or enhanced medical care coverage to individuals and families in a managed care environment for approximately 125,000 low and moderate income residents of New Jersey.

THE PROGRAM:

SERVICES AND HEALTH CARE DELIVERY:

The NJ FamilyCare program will provide four comprehensive packages of health care services (Plans A, B, C, and D), primarily through health maintenance organizations (HMOs) that are currently under contract with the Division of Medical Assistance and Health Services. Each Plan has different conditions that may be applied, depending on the status of the individual or family member. These conditions include services (in and out of the HMO plan), access to fee-for-service until enrollment in managed care, for some beneficiaries, premiums, and copayments. See Attachments A through D for details.

The designated plan for each individual will be identified on the NJ FamilyCare identification card, which will be issued monthly. For individuals in managed care who must pay a copayment, the copayment indicator will be entered on the HMO card after the Plan designation. Copayments are not applicable to a fee-for-service provider,

except Plan D mental health. No family member with a Plan designation of A or B is subject to copayments.

Plan A includes the traditional Medicaid package of services (see Attachment A). All individuals who receive Plan A are entitled to have benefits paid through fee-for-service until enrolled in managed care. All other Plan designations (Plans B, C and D) are only eligible upon enrollment in managed care, for both in-plan and out-of-plan.

PRESUMPTIVE ELIGIBILITY (PE):

Some adults may be determined presumptively eligible for NJ FamilyCare by applying at an approved hospital or Federally Qualified Health Center (FQHC). Covered services are limited to those provided by the hospital and FQHC, plus prescription drugs. See Newsletter, Vol. 10, No. 75 for additional details.

Hospital and FQHC claims related to PE certifications done in September 2000 will not be processed until after October 1, 2000, to allow sufficient time to complete all systems changes. Coverage for pharmacy services related to PE certifications began October 1, 2000.

WORK FIRST NEW JERSEY/GA (WFNJ/GA) CONVERSION TO NJ FAMILYCARE:

Effective September 1, 2000, NJ FamilyCare will cover hospital services on a fee-for-service basis for single individuals and couples without dependent children under the age of 19 who are eligible through WFNJ/GA. Effective November 1, 2000, eligible individuals will begin to enroll in the HMO of their choice.

All claims, including those for hospital services may be submitted under the patient's current WFNJ/GA identification number for dates of service in September and October 2000. However, effective for claims with service dates on or after November 1, 2000, eligible WFNJ/GA beneficiaries' identification numbers will change. The first two positions of the identification number will designate the county where the individual receives assistance, 01 through 21, and the third and fourth positions will be 70.

PAYMENT FOR DRUGS USED IN THE TREATMENT OF AIDS:

NJ FamilyCare participants who are enrolled in Plan A receive certain anti-retroviral drugs through a participating pharmacy (fee-for-service) until they are enrolled in managed care or the AIDS Drug Distribution Program (ADDP).

Except as noted below, upon enrollment in managed care, NJ FamilyCare participants receive anti-retroviral drugs through their HMOs.

All adults, including parents, enrolled in NJ FamilyCare Plan D and those enrolled in Plan A under the WFNJ/GA-related group as identified above, i.e., a 70 in the third and fourth position of the identification number, do not receive their AIDS medications through the HMO. For these adults, such medications are provided fee-for-service until enrollment in ADDP, even after they are enrolled in managed care.

CLAIMS PROCESSING:

The method by which claims are processed does not change for NJ FamilyCare. Fee-for-service claims not covered by the HMO are to be submitted to Unisys, the State's

fiscal agent. Beneficiaries will be enrolled in one of the HMOs available in their county of residence. All covered services provided through the plan are the responsibilities of the participating HMOs, and are to be provided in accordance with policies and procedures established by each HMO.

RETROACTIVE ELIGIBILITY:

Retroactive eligibility for the three month period prior to the month of application for NJ FamilyCare program is available for specified individuals for the payment of unpaid medical bills with dates of service no earlier than July 1, 2000. Generally speaking, only Plan A families, i.e., parents and children, are entitled to this benefit. For those who indicate the need for this coverage, review can be requested at the time of application. However, an applicant can request a subsequent review for a period of 6 months after the date that the original application is submitted. In order to qualify for this benefit, the individual must meet all program requirements during the month that covered services are provided. Plans B, C, and D are not covered.

If you have any questions regarding this newsletter, please contact 1-800-356-1561.

**RETAIN THIS NEWSLETTER NUMERICALLY BEHIND THE NEWSLETTER TAB
(BLUE TAB MARKED "5")**

ATTACHMENT A
NJ FAMILYCARE
PLAN A SERVICE PACKAGE

NOTE: Any family member or adult who receives this plan is entitled to fee-for-service until enrollment in managed care.

Services available through the Health Maintenance Organization (HMO) or through prior approval by the HMO

- Primary and Specialty Care
- Preventive Health Care and Counseling
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Services, including non-legend drugs, ventilator services in the home, and private duty nursing when indicated as a result of an EPSDT screening.
- Emergency Medical Care
- Inpatient Hospital Services, including acute care, rehabilitation and special hospitals.
- Outpatient Hospital Services
- Laboratory Services
- Radiology Services – Diagnostic and Therapeutic
- Prescription Drugs – legend and non-legend covered by the Medicaid program, excluding clozapine, risperidone, olanzapine, quetiapine, methadone, and their generic equivalents.
- Family Planning Services and Supplies
- Audiology Services
- Inpatient Rehabilitation Services
- Podiatrist Services
- Chiropractor Services
- Optometrist Services
- Optical Appliances
- Hearing Aid Services
- Hospice Agency Services
- Durable Medical Equipment (DME)/Assistive Technology Devices
- Medical Supplies
- Prosthetics and Orthotics
- Dental Services
- Organ Transplants – both inpatient and outpatient services for donor and recipient
- Transportation Services, including ambulance, MICUs, and invalid coach
- Post-acute care – Services rendered at an acute care hospital or nursing facility for 30 days or less for inpatient rehabilitation services and provided by a Medicaid participating provider.
- Home Health Agency Services

Services available fee-for-service (FFS)

Note: For mental health services related to clients of the Division of Developmental Disabilities, see Newsletter Vol.10, No. 66.

- Personal Care Assistant Services
- Medical Day Care
- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy, and Speech Pathology
- Abortions and Related Services
- Transportation – lower mode
- Sex abuse examinations
- Services provided by New Jersey Mental Health/Substance Abuse and DYFS Residential Treatment Facilities, Group Homes, or Assisted Living Settings. Medical care required by these residents remains the HMO's responsibility, providing the HMO's provider network and facilities are utilized.
- Family Planning Services and Supplies -- These services are both HMO covered services and also may be covered by the FFS program at the enrollee's option. Medicaid providers may bill the FFS program directly.

- Mental Health Services for all non-DDD beneficiaries
- Substance Abuse: Covered for all non-DDD beneficiaries
- Costs for Methadone and its administration: Covered for all non-DDD beneficiaries
- Clozapine, risperidone, olanzapine, quetiapine and generically-equivalent drug products
- Up to 12 inpatient hospital days when required for social necessity
- DDD/Community Care Waiver special waiver services such as case management and social work services.
- Nursing Facility Care
- Inpatient psychiatric services for individuals under 21 or over 65
- Intermediate Care Facility/Mental Retardation (ICF/MR)

Note:

The NJ FamilyCare "Plan A" service package shall contain those services described in N.J.A.C. 10:49-5.2, except that long term care services shall be restricted to individuals who would qualify for programs for the aged, blind and disabled under Medicaid but for Federal immigration residency restrictions and/or categorical requirements.

**ATTACHMENT B
NJ FAMILY CARE
PLAN B SERVICE PACKAGE**

NOTE: Any child who receives this plan is only entitled to service after enrollment in managed care.

Services available through the Health Maintenance Organization (HMO)

- Primary and Specialty Care
- Preventive Health Care and Counseling
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Services, including early and periodic screening and diagnosis, but only those treatment services identified in the examination that are available under the HMO's benefit package or services specified as fee-for-service.
- Emergency Medical Care
- Inpatient Hospital Services, including acute care, rehabilitation and special hospitals
- Outpatient Hospital Services
- Laboratory Services
- Radiology Services – Diagnostic and Therapeutic
- Prescription Drugs – legend and non-legend covered by the Medicaid program, excluding clozapine, risperidone, olanzapine, quetiapine, methadone, and their generic equivalents
- Family Planning Services and Supplies, when in-plan
- Audiology Services
- Inpatient Rehabilitation Services
- Podiatrist Services
- Chiropractor Services
- Optometrist Services
- Optical Appliances
- Hearing Aid Services
- Hospice Agency Services
- Durable Medical Equipment (DME)/Assistive Technology Devices
- Medical Supplies
- Prosthetics and Orthotics
- Dental Services
- Organ Transplants – both inpatient and outpatient services for donor and recipient
- Transportation Services, including ambulance, MICUs, and invalid coach
- Post-acute care – Services rendered at an acute care hospital or nursing facility for 30 days or less for inpatient rehabilitation services and provided by a Medicaid participating provider
- Home Health Agency Services

Services available fee-for-service (FFS)

- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy, and Speech Pathology, limited to 60 days per type of therapy per year
- Abortions and Related Services
- Sex abuse examinations
- Services provided by New Jersey Mental Health/Substance Abuse and DYFS Residential Treatment Facilities, Group Homes, or Assisted Living Settings. Medical care required by these residents remains the HMO's responsibility, providing the HMO's provider network and facilities are utilized
- Family Planning Services and Supplies -- These services are both HMO covered services and also may be covered by the FFS program at the enrollee's option. Medicaid providers may bill the FFS program directly.
- Mental Health Services
- Substance Abuse Services for all non-DDD beneficiaries.
- Costs for Methadone and its administration
- Clozapine, risperidone, olanzapine, quetiapine, and generically-equivalent drug products
- Up to 12 inpatient hospital days, when required for social necessity

ATTACHMENT C
NJ FAMILY CARE
PLAN C SERVICE PACKAGE

NOTE: Any child enrolled in this plan is required to pay a \$15.00 premium per family

Services available through the Health Maintenance Organization (HMO)

- Primary and Specialty Care, \$5 co-pay
- Preventive Health Care and Counseling
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program Services, including early and periodic screening and diagnosis, but only those treatment services identified in the examination that are available under the HMO's benefit package or services specified as fee-for-service.
- Emergency Medical Care, \$10 co-pay for non-emergency services
- Inpatient Hospital Services, including acute care, rehabilitation and special hospitals
- Outpatient Hospital Services, \$5 co-pay, except for preventive services
- Laboratory Services
- Radiology Services – Diagnostic and Therapeutic
- Prescription Drugs – legend and non-legend covered by the Medicaid program, excluding clozapine, risperidone, olanzapine, quetiapine, methadone, and their generic equivalents, \$5 co-pay for brand name drugs and \$1 co-pay for generic drugs
- Family Planning Services and Supplies, if in-plan
- Audiology Services
- Inpatient Rehabilitation Services
- Podiatrist Services, \$5 co-pay, except for routine care
- Chiropractor Services, spinal manipulation only, \$5 co-pay
- Optometrist Services, \$5 co-pay
- Optical Appliances
- Hearing Aid Services
- Hospice Agency Services
- Durable Medical Equipment (DME)/Assistive Technology Devices
- Medical Supplies
- Prosthetics and Orthotics
- Dental Services, \$5 co-pay, except for preventive services
- Organ Transplants – both inpatient and outpatient services
- Transportation Services, including ambulance, MICUs, and invalid coach
- Post-acute care – Services rendered at an acute care hospital or nursing facility for 30 days or less for inpatient rehabilitation services and provided by a Medicaid participating provider
- Home Health Agency Services

Services available fee-for-service (FFS)

- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy, and Speech Pathology. For Plan C, limited to 60 days per type of therapy per year, except for school-based rehabilitation services
- Abortions and Related Services
- Sex abuse examinations
- Services provided by New Jersey Mental Health/Substance Abuse and DYFS Residential Treatment Facilities, Group Homes, or Assisted Living Settings. Medical care required by these residents remains the HMO's responsibility, providing the HMO's provider network and facilities are utilized.
- Family Planning Services and Supplies -- These services are both HMO covered services and also may be covered by the FFS program, at the enrollee's option. Medicaid providers may bill the FFS program directly.
- Home Health Agency Services
- Mental Health Services
- Substance Abuse Services
- Costs for Methadone and its administration
- Clozapine, risperidone, olanzapine, quetiapine, and generically-equivalent drug products
- Up to 12 inpatient hospital days, when required for social necessity

ATTACHMENT D
NJ FAMILY CARE
PLAN D SERVICE PACKAGE

NOTE: Any family member or adult enrolled in this plan is only eligible for service after enrollment in managed care. Premiums and co-payments are required for families and children with income greater than 150% of the Federal poverty level.

Services available through the Health Maintenance Organization (HMO)

- Primary and Specialty Care, \$5 co-pay, except for preventive services
- Well child care, including immunization, and lead screening and treatments
- Emergency Room Services, with \$35 co-pay for non-emergency treatment
- Family Planning Services and Supplies, including: Medical history and physical exams, diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices, counseling, continuing medical supervision, continuity of care and genetic counseling
- Home Health Care Services, limited to skilled nursing care for a home-bound beneficiary which is provided or supervised by a registered nurse when the purpose of the treatment is skilled care necessary for the treatment of the beneficiary's medical condition
- Hospice Services
- Inpatient Hospital Services, including acute care, rehabilitation and special hospitals
- Outpatient Hospital Services, including outpatient surgery, \$5 co-pay, except for preventive services
- Laboratory Services, \$5 co-pay
- Radiology Services – Diagnostic and Therapeutic, \$5 co-pay
- Optometrist Services: Including one routine eye examination per year, \$5 co-pay
- Optical Appliances: Limited to one pair of glasses (or contact lenses) per 24 month period, or as medically necessary
- Organ Transplants
- Prescription Drugs, excluding over-the-counter drugs, \$5 co-pay for brand name drugs and \$1 co-pay for generic drugs
- Dental Services, limited to preventive dental services only for children under the age of 12 years; including oral exams, oral prophylaxis, and topical application of fluorides
- Podiatrist Services, excluding routine hygienic care of feet in the absence of a pathological condition, \$5 co-pay
- Prosthetic Appliances, limited to initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury, or congenital defect
- Private Duty Nursing, when authorized by the HMO
- Transportation Services, limited to ambulance services for medical emergency only
- Maternity and related newborn care
- Diabetic Supplies and Equipment

Services available fee-for-service (FFS)

- Abortion Services
- Skilled Nursing Facility Services
- Outpatient Rehabilitation – Physical Therapy, Occupational Therapy, and Speech Pathology: Limited to: 1) non-chronic conditions and acute illnesses and injuries; and 2) 60 consecutive day period per incident of illness or injury beginning with the first day of treatment per contract year. Speech therapy rendered for treatment of delays in speech development, unless resulting from disease, injury or congenital defects, is not covered.
- Inpatient Hospital Services for Mental Health, including psychiatric hospitals, limited to 35 days per year
- Outpatient Benefits for Short-Term, Outpatient Evaluative and Crisis Intervention, or Home Health Mental Health Services, limited to 20 visits per year, \$25 co-pay:

1. When authorized by DMAHS, one (1) mental health inpatient day may be exchanged for up to four (4) home health visits or four (4) outpatient services, including partial care. Limited to an exchange of up to a maximum of 10 inpatient days for a maximum of 40 additional outpatient visits.
 2. When authorized by DMAHS, one (1) mental health inpatient day may be exchanged for two (2) days of treatment in partial hospitalization up to the maximum number of covered inpatient days.
- Inpatient and Outpatient Substance Abuse: Limited to detoxification, \$25 co-pay for outpatient visits

NOTE: Co-pays are not required for General Assistance/NJ FamilyCare or for adults when income is above 50% of the Federal Poverty Line, up to 150% of the Federal Poverty Line.